ADMINISTRATION OFFICE

4th DISTRICT IBEW HEALTH FUND

609 3rd Avenue • P.O. Box 487 • Chesapeake, OH 45619

Telephone: (304) 525-0331 • Fax: (740) 867-4300

www.4thdistricthealthfund.com

ENROLLMENT FORM

Please complete and return to the above address as soon as possible. Claims will be denied until this information is received, and our files are updated.

MEMBER INFORMATION

Member's Name:_____ Member's SSN:_____

Member's Address:_____

Member's Telephone No._____ Member's Date of Birth:_____

Member's Marital Status:_____ Gender: _____ Member's Local Union #:_____

Member's Current Employer: _____

If you are receiving either of the following benefits, please note which one and the date the benefits began.

____ Social Security Disability Benefits Effective Date of Social Security Disability: ___/___/___

____ Workers' Compensation Benefits Effective Dare of Workers' Compensation: ___/___/___

SPOUSE INFORMATION

**** A COPY OF YOUR MARRIAGE CERTIFICATE MUST BE ATTACHED. ***

Spouse's Name: _____ Spouse's SSN: _____

Spouse's Employer: _____ Spouse's Date of Birth: _____

Spouse's Insurance Co.: _____ Policy #: _____

DEPENDENT INFORMATION

List all unmarried dependent children under the age of 19 (or 24 if a student). For all children 19 through 23 years of age, verification of student status is required in order to continue coverage. Please request a Student Form from the Administration Office or download it from the Fund's Web site at www.4thdistricthealthfund.com if applicable. Please complete the reverse side of this form for each child not born of your current marriage.

	Full Name	Relationship to Employee	SSN	Date of Birth	Gender
1.					
2.					
3.					
4.					
5.					

Member Signature: _____ Date Signed:_____

DEPENDENT CHILD INFORMATION

1. Please complete the section below for any child not born of your current marriage. Send a copy of the natural parent's Divorce Decree, so it may be determined who has the responsibility for the child's medical coverage.

A. Child's Name: _____ Relationship:_____

B. If the Natural Mother is not covered by the 4th District IBEW Health Fund, please complete the following:
Natural Mother's Name: _____ SSN_____
Natural Mother's Address: _____
Natural Mother's Employer's Name & Address: _____
_____
Natural Mother's Insurance Co. Name & Address: _____
_____ Policy No._____

C. If the Natural Father is not covered by the 4th District IBEW Health Fund, please complete the following:
Natural Father's Name: _____ SSN _____
Natural Father's Address:_____
Natural Father's Employer's Name & Address: _____
Natural Father's Insurance Co. Name & Address: _____
_____ Policy No._____

D. Name of Parent with Custody of Child: _____

2. For each child not born of your current marriage, please provide the answers to questions A through D above on a separate sheet of paper and attach to this form.

3. Verification of student status is required for each child from age 19 through 23 each September and January. Forms may be obtained from the Administration Office or online at ww.4thdistricthealthfund.com. Claims cannot be paid without this form.

4. For any child who is your natural child but not born of a valid marriage and does not reside with you, please submit a copy of the Court Decree relating to the responsibility for medical benefits.