I.B.E.W. LOCAL 25 HEALTH & BENEFIT FUND SURVEY

*****IMPORTANT** This document must be submitted to the fund office (to insure your spouse and children if applicable) with a copy of your marriage certificate, birth certificates and social security cards.***

Benefit eligibility is contingent on receipt of the above mentioned documents.

YOUR NAME YOUR DATE OF BIRTH YOUR SOC. SEC. NO.

YOUR STREET ADDRESS

TOWN/CITY, STATE, & ZIP CODE

TELEPHONE NO. ( ) _____ E-MAIL _____

NAME OF SPOUSE SPOUSE'S DATE OF BIRTH SPOUSE'S SOC. SEC. NO

IS YOUR SPOUSE EMPLOYED? _____
DO YOU OR YOUR SPOUSE HAVE ANY OTHER HEALTH, DENTAL, PRESCRIPTION OR VISION COVERAGE? _____

IF YES, FILL IN THE NAME, ADDRESS, AND POLICY NO. OF THE CARRIER BELOW. (Indicate whether the coverage is yours or your spouse's and if it is single or family coverage) **PROVIDE FRONT & BACK COPY OF CARD.**

LIST YOUR CHILDREN, AGE 26 OR UNDER (see "Eligible Dependent" Definitions in your Summary Plan Description)

Name of Child	Date of Birth	Son/Daughter	Soc.Sec.#
1.			
2.			
3.			
4.			
5.			

I KNOW IT IS A CRIME TO COMPLETE THIS FORM WITH INFORMATION I KNOW IS FALSE OR TO OMIT ANY FACTS I KNOW ARE IMPORTANT.

DATE SIGNED:_____ SIGNATURE:_____