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

Please complete the following health survey and return to The Fund office to verify we have accurate health information. This Survey is used for coordination of coverage as well as adding on eligible dependents. If you the participant are currently enrolled in another plan it is important the fund is notified. This survey must be completed by the participant and submitted to the Fund office in order to process claims correctly.

If adding on dependents The Fund will require a copy of your marriage certificate, birth certificates and social security cards for all of the individuals you wish to add. Benefit eligibility is contingent on the receipt of the above-mentioned documents

PARTICIPANT'S NAME	PATRICIPANT'S D.O.B	PARTICIPANT'S SSN
PARTICIPANT'S ADDRESS	**PHONE NUMBER**	**EMAIL**

DO YOU CURRENTLY HAVE HEALTH OTHER COVERAGE ? ☐ **YES** ☐ **NO**

**If yes, please complete the following and provide copies of insurance cards*

Type of coverage:

☐ **Medical** ☐ **Dental** ☐ **Vison** ☐ **Pharmacy**

Name of other insurance _____

Policy number _____

Effective Date _____ **Termination Date** _____

Policy Holder_____

Relationship to Policy Holder_____

Do you plan on terminating from your other insurance ? _____

*If yes the Fund will require a termination letter from the other insurance to coordinate the benefits correctly. If you plan on having dual coverage a determination will be made as to which plan is the "primary" plan once all information is received. Failing to return this survey with accurate information will result in billing issues and the participant will be responsible for balanced bills for failing to notify The Fund of coordination of coverage

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

SIGNATURE OF PARTICIPANT: _____

DATE: _____

continue on next page to add dependents

If you have any questions regarding the enclosed forms, please contact the Fund office prior to completion

SPOUSE/DEPENDENT(S) INFORMATION

SPOUSE'S NAME	SPOUSE'S D.O.B	SPOUSE'S SSN

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

NAME OF CHILD	DATE OF BIRTH	SON/DAUGHTER	SSN

DOES YOUR SPOUSE CURRENTLY HAVE OTHER HEALTH COVERAGE? ☐ **YES** ☐ **NO**
**If yes, please complete the following and provide copies of insurance cards*

Type of coverage:
☐ **Medical** ☐ **Dental** ☐ **Vison** ☐ **Pharmacy**

Who else is covered under this policy?

Name _____ **Date of Birth**_____

Name _____**Date of Birth**_____

Name _____**Date of Birth** _____

Name of other insurance _____

Policy number _____

Effective Date _____ **Termination Date** _____

Policy Holder_____

Relationship to Policy Holder_____

Do you plan on terminating your current insurance ? _____

*If yes the Fund will require a termination letter from the other insurance to coordinate the benefits correctly. If you plan on having dual coverage a determination will be made as to which plan is the "primary" plan once all information is received. Failing to return this survey with accurate information will result in billing issues and the participant will be responsible for balanced bills for failing to notify The Fund of coordination of coverage

DOES YOUR CHILD(CHILDREN) HAVE OTHER HEALTH COVERAGE? ☐ **YES** ☐ **NO**
**If yes, please complete the following and provide copies of insurance cards*

Type of coverage:
☐ **Medical** ☐ **Dental** ☐ **Vison** ☐ **Pharmacy**

Who else is covered under this policy?

Name _____ **Date of Birth**_____

Name _____**Date of Birth**_____

Name _____**Date of Birth** _____

Name of other insurance _____

Policy number _____

Effective Date _____ **Termination Date** _____

Policy Holder_____

Relationship to Policy Holder_____

Do you plan on terminating your current insurance ? _____

*If yes the Fund will require a termination letter from the other insurance to coordinate the benefits correctly. If you plan on having dual coverage, a determination will be made as to which plan is the "primary" plan once all information is received. Failing to return this survey with accurate information will result in billing issues and the participant will be responsible for balanced bills for failing to notify The Fund of coordination of coverage

I AUTHORIZE THE FUND TO ADD ON MY SPOUSE/DEPENDENTS TO MY HEALTH COVERAGE. 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.

SIGNATURE OF PARTICIPANT: _____

DATE: _____