

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

Please complete this health survey and return it to the Fund office so we can verify that your health information is accurate. The survey is used to coordinate coverage and add eligible dependents. If you are currently enrolled in another health plan you must notify the Fund. The participant must complete and submit this survey to the Fund office to ensure that claims are processed correctly. If you are adding dependents, the Fund requires copies of the marriage certificate, birth certificates, and Social Security cards for all individuals you wish to add. Eligibility for benefits is contingent upon receipt of these documents. If the address we have on file is different from your current address, please complete the attached Change of Information Form. The form must be notarized due to the Fund's identity theft prevention procedures.

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

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

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

Type of coverage:

☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy

Is this a Medicaid plan? ☐ YES ☐ NO

Is this a Medicare plan? ☐ YES ☐ NO

Name of Other Insurance _____

Policy Number _____

Effective Date _____ **Termination Date** _____

Policyholder _____

Relationship to Policyholder _____

Do you plan to terminate your other insurance? _____

**If yes, the Fund requires a termination letter from the other insurer to coordinate benefits correctly. If you plan to maintain dual coverage, the Fund will determine which plan is primary after receiving all required information. Failure to return this survey with accurate information may cause billing issues, and the participant may be responsible for balance bills resulting from failure to notify the Fund about other coverage.*

I UNDERSTAND THAT IT IS A CRIME TO PROVIDE INFORMATION ON THIS FORM THAT I KNOW IS FALSE OR TO OMIT FACTS THAT I KNOW ARE IMPORTANT.

SIGNATURE OF PARTICIPANT: _____

DATE: _____

SPOUSE/DEPENDENT INFORMATION

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

LIST YOUR CHILDREN AGED 26 OR YOUNGER

(See the "Eligible Dependent" definition in your Summary Plan Description.)

NAME OF CHILD	DATE OF BIRTH	SON/DAUGHTER STEPSON/STEPDAUGHTER	SSN

DOES YOUR SPOUSE CURRENTLY HAVE OTHER HEALTH COVERAGE?

☐ YES ☐ NO

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

Type of coverage:

☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy

Is this a Medicaid plan? ☐ YES ☐ NO

Is this a Medicare plan? ☐ YES ☐ NO

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 _____

Policyholder _____

Relationship to Policyholder _____

Do you plan to terminate your other insurance? _____

**If yes, the Fund requires a termination letter from the other insurer to coordinate benefits correctly.*

If you plan to maintain dual coverage, the Fund will determine which plan is primary after receiving all required information. Failure to return this survey with accurate information may cause billing issues, and the participant may be responsible for balance bills resulting from failure to notify the Fund about other coverage.

SPOUSE/DEPENDENT INFORMATION, CONTINUED

DOES YOUR CHILD (CHILDREN) HAVE OTHER HEALTH COVERAGE?

☐ YES ☐ NO

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

Type of coverage:

☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy

Is this a Medicaid plan? ☐ YES ☐ NO

Is this a Medicare plan? ☐ YES ☐ NO

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** _____

Policyholder _____

Relationship to Policyholder _____

Do you plan to terminate your other insurance? _____

**If yes, the Fund requires a termination letter from the other insurer to coordinate benefits correctly. If you plan to maintain dual coverage, the Fund will determine which plan is primary after receiving all required information. Failure to return this survey with accurate information may cause billing issues, and the participant may be responsible for balance bills resulting from failure to notify the Fund about other coverage.*

If you have questions about this survey, please contact the Fund office before completing it.

I AUTHORIZE THE FUND TO ADD MY SPOUSE AND/OR DEPENDENTS TO MY HEALTH COVERAGE. I UNDERSTAND THAT IT IS A CRIME TO PROVIDE INFORMATION ON THIS FORM THAT I KNOW IS FALSE OR TO OMIT FACTS THAT I KNOW ARE IMPORTANT.

SIGNATURE OF PARTICIPANT: _____

DATE: _____

ELECTRICAL INDUSTRY BOARD

372 Vanderbilt Motor Parkway, Hauppauge, NY 11788-5133
631-434-3344

CHANGE OF PERSONAL INFORMATION FORM

Please change your record of address for the below participant on file with the I.B.E.W. Local 25 Health & Benefit Fund, I.B.E.W. Local 25 Pension Fund, I.B.E.W. Local 25 401(k) Fund, Annuity Fund of the Electrical Industry of Long Island and/or the I.B.E.W. Local 25 Vacation/Holiday Trust Fund. Please note that if you are retired receiving benefits paid through the Prudential Insurance Company on behalf of the I.B.E.W. Local 25 Pension Fund, you must contact Prudential directly at 1-800-621-1089.

CURRENT CONTACT INFORMATION

Participants Name : _____

Social Security #. : _____

Previous Address: _____

Previous Telephone Number: _____

Previous email address: _____

NEW CONTACT INFORMATION

New Address: _____

New Telephone Number: _____

New email address: _____

Date _____ Participant Signature _____

Signatures that are not notarized will not be accepted.

STATE OF)
) ss.:
COUNTY OF)

On this ____ day of _____, 20____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the foregoing and acknowledged to me that (s)he executed the same in his/her capacity.

NOTARY PUBLIC

(Seal)