

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

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



ENROLLMENT FORM INSTRUCTIONS

STEP 1 - COMPLETE THE APPLICABLE ENROLLMENT PAGES

Page 2 - Participant information and other health coverage. Complete and sign this page for yourself.

If you are NOT adding dependents, you may return page 2 only with any required documentation. Pages 3 and 4 - Complete only if adding or updating a spouse or dependent child.

Page 5 - Change of Personal Information Form; complete only if your address or contact details changed.

STEP 2 - ATTACH REQUIRED DOCUMENTS

For all participants: copies of any other health insurance cards; termination letter if ending other coverage.

If adding a spouse: marriage certificate, birth certificate, and Social Security card.

If adding children: birth certificate and Social Security card for each child.

If adding stepchildren / children of separated or divorced parents: Judgment of Divorce (JOD) including custody/insurance provisions; or, if separated or no JOD is available, a notarized statement identifying custody and responsibility for health coverage.

The Fund may request additional documentation, including applicable court orders.

COORDINATION OF BENEFITS AND IMPORTANT INFORMATION

Notify the Fund if you or your dependents have other health insurance. The Fund will determine primary and secondary coverage once all required information has been received.

Eligible dependents may not be covered for claims arising more than 30 days before registration. A notarized Change of Personal Information Form is required for address changes.

HOW TO RETURN YOUR FORM

Mail or deliver: 372 Vanderbilt Motor Parkway, Hauppauge, NY 11788-5133.

Email: elizabeth@eibofli.com | Fax: 631-434-3397, ATTN: Medical Dept.

Questions? Elizabeth: 631-434-3344 ext. 306 | Direct: 631-609-3927.

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ENROLLMENT FORM - PARTICIPANT ONLY

Complete this page even if you are not enrolling dependents. Sign and return this page.

SECTION ONE - PARTICIPANT INFORMATION

PARTICIPANT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

SECTION TWO - PARTICIPANT OTHER HEALTH COVERAGE

Do you currently have other health insurance?

☐ Yes

☐ No

If yes, attach the insurance card and complete the following.

Coverage type: ☐ Medical

☐ Dental

☐ Vision

☐ Pharmacy

Medicaid? ☐ Yes

☐ No

Medicare plan?

☐ Yes

☐ No

NAME OF OTHER INSURANCE		POLICY NUMBER	
EFFECTIVE DATE	TERMINATION DATE	POLICYHOLDER	RELATIONSHIP TO POLICYHOLDER

Do you plan to terminate this other insurance?

☐ Yes

☐ No

If yes, attach a termination letter from the other insurer.

PARTICIPANT ACKNOWLEDGMENT

I understand that I must notify the Fund of changes to my other health insurance coverage. I understand that it is a crime to provide information I know is false or omit important facts.

Participant signature: _____ Date: _____

NO DEPENDENTS TO ADD? Return this signed page only, with applicable supporting documents.

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DEPENDENT ENROLLMENT - COMPLETE ONLY IF APPLICABLE

Participant name: _____

SECTION THREE - SPOUSE / DEPENDENT INFORMATION

SPOUSE NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

List eligible children being added or updated. Refer to the SPD definition of Eligible Dependent.

CHILD NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NUMBER

Are any children stepchildren or children of separated/divorced parents? ☐ Yes ☐ No

If yes, submit the applicable custody/insurance documentation listed on page 1.

SECTION FOUR - SPOUSE OTHER HEALTH COVERAGE

Does your spouse have other health coverage? ☐ Yes ☐ No

If yes, attach the insurance card and complete the following.

Coverage type: ☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy

Medicaid? ☐ Yes ☐ No Medicare? ☐ Yes ☐ No

NAME OF OTHER INSURANCE		POLICY NUMBER	
EFFECTIVE DATE	TERMINATION DATE	POLICYHOLDER	RELATIONSHIP

Do you plan to terminate this other insurance? ☐ Yes ☐ No

If yes, attach a termination letter.

WHO ELSE IS COVERED UNDER THIS POLICY?

NAME	DATE OF BIRTH

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DEPENDENT ENROLLMENT - CHILDREN OTHER COVERAGE

Participant name:

SECTION FIVE - CHILDREN OTHER HEALTH COVERAGE

Do your children have other health coverage?

☐ Yes

☐ No

If yes, attach the insurance card and complete the following.

Coverage type: ☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy

Medicaid? ☐ Yes ☐ No

Medicare? ☐ Yes ☐ No

NAME OF OTHER INSURANCE		POLICY NUMBER	
EFFECTIVE DATE	TERMINATION DATE	POLICYHOLDER	RELATIONSHIP

Do you plan to terminate this other insurance?

☐ Yes

☐ No

If yes, attach a termination letter from the other insurer.

NAME AND RELATIONSHIP OF PARENT / PERSON PROVIDING OTHER COVERAGE

NAME	RELATIONSHIP TO CHILD

WHO ELSE IS COVERED UNDER THIS POLICY?

NAME	DATE OF BIRTH

DEPENDENT ENROLLMENT AUTHORIZATION

I authorize the Fund to add my eligible spouse and/or dependents to my health coverage. I will report changes to other coverage and certify that the information provided is accurate.

Participant signature:

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)