INDIANA LABORERS WELFARE FUND
P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587
Telephone (812) 238-2551 Toll Free (800) 962-3158
Fax (812) 238-2553 www.IndianaLaborers.org

DEPENDENT ENROLLMENT FORM

Participant Name: ______________________ ID#:_____________________

I request the following dependent(s) be included in my health benefit plan coverage through Indiana Laborers Welfare Fund. *Dependent(s) listed below are in* <u>*addition*</u> *to those already covered.*

Name of Dependent	**Social Security Number (must be provided)**	**Date of Birth**	**Gender**	**Relationship to Participant**

The following information must also be submitted with this form:

Spouse: copy of your marriage certificate and a new beneficiary designation form (please request this form if not already in your possession).

Child: copy of the birth certificate, paternity papers or adoption order.

Step-child: copy of the birth certificate, your marriage certificate, divorce decree and/or affidavit.

______________________________ ____________________
Participant Signature Date

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