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: _____

Participant SSN or ID#: _____

I request the following Dependent(s) be included in my health plan benefit coverage through the Indiana Laborers Welfare Fund:

Dependent Name	Social Security #	Date of Birth	Gender	Relationship to Participant

You MUST list all Dependent(s) to be covered through the Indiana Laborers Welfare Fund health plan benefit coverage and provide the necessary documentation for any new Dependent(s) being added; such as, birth certificate, marriage certificate, paternity papers, divorce decree or affidavit.

If you wish to change your Beneficiary please request a new Beneficiary Designation Form (registration card) from the Fund Office.

_____ _____

Participant Signature Date