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# APPLICATION FOR SPOUSAL/DEPENDENT REENROLLMENT OF COVERAGE FROM THE INDIANA LABORERS WELFARE FUND

Plan Participant Name:_____ Spouse's Name: _____

Plan Participant's SSN or Member ID: _____

I hereby request to reactivate coverage under the Indiana Laborers Welfare Fund due to termination of eligibility under a high deductible health care plan with my current employer.

I wish to reactivate my coverage with the Indiana Laborers effective: _____

_____(initial) I have attached proof of termination of coverage with my employer.

Reenrollment applies to the following dependents as well:

| Dependent Name | Birth Date | Relationship to Insured |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

_____
Signature of Spouse

_____
Signature of Plan Participant

_____
Date

***For Fund Office Use Only***

Date approved by Plan: _____

Effective date of termination: _____