Local No. 9, IBEW and Outside Contractors Health and Welfare Fund

Annual Family Information Survey and Confirmation of Other Medical Coverage

YOU MUST COMPLETE THIS
FORM EACH YEAR - You
must supply ALL info
requested - Your claims for
the new year will be denied
until this form is returned

Member Information		Would you like to receive plan updates via email? Yes! No th				No thanks		
NAME (FIRST, MIDDLE, LAST)					(MAIDEN)			
SOCIAL SECURITY NUMBER B		BCBS ID NO. on Member's BCBS card		DATE OF BIRTH (MM/DD/YYYY)				
STREET ADDRESS		CITY		STATE ZIP				
EMAIL		HOME PHONE include area code		MOBILE PHONE include area code				
MARITAL STATUS Check one: Single	Marrie	ed Date: Month / Day / Year	Divorced Date: Mor	Month / Day / Year Widowed Date: Month / Day / Year				
IS MEMBER ON MEDICARE? Yes		☐ No If yes, Medicare Claim No.						
If yes, Medicare Part A effective date If yes, Medica		dicare Part B effective date	If yes, Medicare Part C effective date			Part D effective date		
DOES MEMBER HAVE HEALTH CARE COVERAGE UNDER ANY OTHER PLAN, INCLUDING ANY MEDICARE SUPPLEMENT? Yes No If yes, complete the rest of this section								
NAME OF PLAN		POLICYHOLDER'S NAME		POLICYHOLDER'S ID NUMBER				
GROUP OR PLAN NUMBER		TYPE OF COVERAGE IN THIS PLAN (check all that apply):			ISION DRUG			
Spouse Informatio	n	Would you like to re	eceive plan update	es via email?	Yes!	No thanks		
Spouse Informatio	n	Would you like to re	eceive plan update	es via email?	Yes!	No thanks		
<u> </u>	n	Would you like to re		Check here if m	nailing address is th	No thanks e same as the Member's		
NAME (FIRST, MIDDLE, LAST)	n	Would you like to re	SOCIAL SECURITY NUMBER MAILING INFORMATION	Check here if m	nailing address is th			
NAME (FIRST, MIDDLE, LAST) DATE OF BIRTH (MM/DD/YYYY)	n	Would you like to re	MAILING INFORMATION mailing address. If different CITY	Check here if m	nailing address is th	e same as the Member's		
NAME (FIRST, MIDDLE, LAST) DATE OF BIRTH (MM/DD/YYYY) STREET ADDRESS	n		MAILING INFORMATION mailing address. If different CITY	Check here if m	nailing address is th low. STATE	e same as the Member's		
NAME (FIRST, MIDDLE, LAST) DATE OF BIRTH (MM/DD/YYYY) STREET ADDRESS EMAIL		HOME PHONE include area code	MAILING INFORMATION mailing address. If different CITY	Check here if nt, please provide be	nailing address is th low. STATE E include area code	e same as the Member's		
NAME (FIRST, MIDDLE, LAST) DATE OF BIRTH (MM/DD/YYYY) STREET ADDRESS EMAIL IS SPOUSE ON MEDICARE? Yes	If yes, Mec	HOME PHONE include area code No licare Part B effective date	MAILING INFORMATION mailing address. If different CITY If yes, Medicare Claim No.	Check here if mt, please provide be MOBILE PHONI	nailing address is the low. STATE include area code If yes, Medicare	e same as the Member's ZIP		
NAME (FIRST, MIDDLE, LAST) DATE OF BIRTH (MM/DD/YYYY) STREET ADDRESS EMAIL IS SPOUSE ON MEDICARE? Yes If yes, Medicare Part A effective date	If yes, Mec	HOME PHONE include area code No licare Part B effective date	MAILING INFORMATION mailing address. If different CITY If yes, Medicare Claim No.	Check here if mt, please provide be MOBILE PHONI	nailing address is the low. STATE include area code If yes, Medicare	e same as the Member's ZIP Part D effective date		
NAME (FIRST, MIDDLE, LAST) DATE OF BIRTH (MM/DD/YYYY) STREET ADDRESS EMAIL IS SPOUSE ON MEDICARE? Yes If yes, Medicare Part A effective date DOES SPOUSE HAVE COVERAGE UNDER ANY OF	If yes, Mec	HOME PHONE include area code No dicare Part B effective date	MAILING INFORMATION mailing address. If different CITY e If yes, Medicare Claim No. If yes, Medicare Part C effe	Check here if mt, please provide be MOBILE PHONI Continue date Yes No	address is the low. STATE E include area code If yes, Medicare o If yes, complete or the low of	e same as the Member's ZIP Part D effective date		

Wait! You must report children on the reverse side of this form

IF MEMBER HAS MORE THAN 3 CHILDREN, PLEASE PROVIDE INFORMATION ON A SEPARATE SHEET OF PAPER (you may copy this form).

If member is adding a spouse or child dependent(s) under the age of 18 via this form, an original or certified copy of the county- or state-issued marriage license (if adding a spouse) or an original or certified copy of the county- or state-issued birth certificate with the member named as the parent (if adding a child) must accompany this form. To add an adult child dependent 18 years or older, you cannot do so with this form; instead you must submit the Special Adult Child Enrollment Form (download from www.efringes.net or request the form from the Fund Office). If terminating spousal or dependent coverage you must request and submit a Dependent Dis-Enrollment Form. ALL DOCUMENTS ARE RETURNED TO THE MEMBER AFTER INSPECTION. I hereby confirm that the information provided on this form is true and correct:

MEMBER SIGNATURE DATE

Return this form to: Local 9, IBEW and Outside Contractors Health and Welfare Fund, One Westbrook Corporate Center, Ste 430, Westchester IL 60154.

Direct inquiries to 866-661-1021, option 0.

·									
Child 1 NAME (FIRST, MIDDLE, LAST)		SOCIAL SECURITY NUMBER							
DATE OF BIRTH (MM/DD/YYYY)	MAILING INFORMATION Check here if mailing address is the same as the Member's mailing address. If different, please provide below.								
STREET ADDRESS	CITY		STATE	ZIP					
EMAIL HOME PHONE incl	lude area code		MOBILE PHONE	include area code					
IS CHILD ON MEDICARE? Yes No		MEDICARE CLAIM NO.							
If yes, Medicare Part A effective date If yes, Medicare Part B effective d	date	If yes, Medicare Part C effecti	live date If yes, Medicare Part D effective date						
DOES CHILD HAVE HEALTH CARE COVERAGE UNDER ANY OTHER PLAN, INCLUDING THE NON-MEMBER PARENT, THE CHILD'S SPOUSE OR DOMESTIC PARTNER, OR ANY MEDICARE SUPPLEMENT? Yes No If yes, complete the rest of this section									
NAME OF PLAN	POLICYHOLI								
GROUP OR PLAN NUMBER	TYPE OF CO	VERAGE IN THIS PLAN (check y):	MEDICAL DENTAL VISION DRUG						
PHONE NUMBER CLAIM MAILING ADDRESS									
Child 2 NAME (FIRST, MIDDLE, LAST)		SOCIAL SECURITY NUMBER							
DATE OF BIRTH (MM/DD/YYYY)		ATION Check here if mailing address is the same as the Member's f different, please provide below.							
STREET ADDRESS		CITY	STATE ZIP						
EMAIL HOME PHONE incl	lude area code		MOBILE PHONE	include area code					
IS CHILD ON MEDICARE? Yes No		MEDICARE CLAIM NO.							
If yes, Medicare Part A effective date If yes, Medicare Part B effective d	If yes, Medicare Part C effecti	tive date If yes, Medicare Part D effective date							
DOES CHILD HAVE HEALTH CARE COVERAGE UNDER ANY OTHER PLAN, INCLUDING THE NON-MEMBER PARENT, THE CHILD'S SPOUSE OR DOMESTIC PARTNER, OR ANY MEDICARE SUPPLEMENT? Yes No If yes, complete the rest of this section									
NAME OF PLAN	POLICYHOLI	DER'S NAME	POLICYHOLDER'S ID NUMBER						
GROUP OR PLAN NUMBER	TYPE OF CO' all that appl	VERAGE IN THIS PLAN (check y):	MEDICAL	DENTAL VISIO	ON DRUG				
PHONE NUMBER CLAIM MAILING ADDRESS									
Child 3 NAME (FIRST, MIDDLE, LAST)		SOCIAL SECURITY NUMBER							
DATE OF BIRTH (MM/DD/YYYY)	_	NLING INFORMATION Check here if mailing address is the same as the Member's silling address. If different, please provide below.							
STREET ADDRESS	CITY		STATE	ZIP					
EMAIL HOME PHONE incl	lude area code		MOBILE PHONE	include area code					
IS CHILD ON MEDICARE? Yes No	MEDICARE CLAIM NO.								
If yes, Medicare Part A effective date If yes, Medicare Part B effective d	If yes, Medicare Part C effecti	yes, Medicare Part C effective date If yes, Medicare Part D effective date							
DOES CHILD HAVE HEALTH CARE COVERAGE UNDER ANY OTHER PLAN, INCLUDING THE NON-MEMBER PARENT, THE CHILD'S SPOUSE OR DOMESTIC PARTNER, OR ANY MEDICARE SUPPLEMENT? Yes No If yes, complete the rest of this section									
NAME OF PLAN	·p	LDER'S NAME POLICYHOLDER'S IE		R'S ID NUMBER					
GROUP OR PLAN NUMBER	TYPE OF CO'	OVERAGE IN THIS PLAN (check MEDICAL DENTAL VISION DRUG							
PHONE NUMBER		CLAIM MAILING ADDRESS							

More than 3 children to report? Please copy this page to report them

=== You must complete this form each year ===

To prevent denial of claims submit this completed form ASAP