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 thanks

NAME (FIRST, MIDDLE, LAST) (MAIDEN)

SOCIAL SECURITY NUMBER	BCBS ID NO. on Member's BCBS card	DATE OF BIRTH (MM/DD/YYYY)
	BWL	

STREET ADDRESS | CITY | STATE | ZIP

EMAIL | HOME PHONE include area code | MOBILE PHONE include area code

MARITAL STATUS Check one: ☐ Single ☐ Married Date: Month / Day / Year ☐ Divorced Date: 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, Medicare Part B effective date | If yes, Medicare Part C effective date | If yes, Medicare 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): ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ DRUG

Spouse Information

Would you like to receive plan updates via email? ☐ Yes! ☐ No thanks

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 include area code | MOBILE PHONE include area code

IS SPOUSE ON MEDICARE? ☐ Yes ☐ No If yes, Medicare Claim No.

If yes, Medicare Part A effective date | If yes, Medicare Part B effective date | If yes, Medicare Part C effective date | If yes, Medicare Part D effective date

DOES SPOUSE HAVE COVERAGE UNDER ANY OTHER PLAN, INCLUDING ANY MEDICARE SUPPLEMENT or an EMPLOYER? ☐ 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): ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ DRUG

PHONE NUMBER | CLAIM MAILING ADDRESS

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 include 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 date | If 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 | POLICYHOLDER'S NAME | POLICYHOLDER'S ID NUMBER

GROUP OR PLAN NUMBER | TYPE OF COVERAGE IN THIS PLAN (check all that apply): ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ DRUG

PHONE NUMBER | CLAIM MAILING ADDRESS

Child 2

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 include 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 date | If 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 | POLICYHOLDER'S NAME | POLICYHOLDER'S ID NUMBER

GROUP OR PLAN NUMBER | TYPE OF COVERAGE IN THIS PLAN (check all that apply): ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ DRUG

PHONE NUMBER | CLAIM MAILING ADDRESS

Child 3

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 include 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 date | If 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 | POLICYHOLDER'S NAME | POLICYHOLDER'S ID NUMBER

GROUP OR PLAN NUMBER | TYPE OF COVERAGE IN THIS PLAN (check all that apply): ☐ 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

If this form is not filled out in its entirety it will be sent back to you to be completed