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 addition 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, divorce decree (if parents divorced), paternity papers (if member not listed on birth certificate) or adoption order.

Step-child: copy of the birth certificate, your marriage certificate and copy of natural parent's divorce decree.

_____ _____
Participant Signature Date