



IBEW Local 43

Health and Prescription Benefits Plan Enrollment Form

I. ENROLLEE INFORMATION					
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	PHONE NUMBER
STREET ADDRESS AND APT NUMBER		CITY & STATE		ZIP CODE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
HIRE DATE	MARITAL STATUS AND DATE <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> DATE OF MARRIAGE _____				
DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICARE NUMBER	MEDICARE EFFECTIVE DATE: PART A EFFECTIVE DATE ___/___/___ "PART B" EFFECTIVE DATE ___/___/___ "PART D" EFFECTIVE DATE ___/___/___			
EMPLOYMENT STATUS: <input type="checkbox"/> ACTIVE <input type="checkbox"/> COBRA <input type="checkbox"/> RETIRED UNDER 65			MEDICAL COVERAGE: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/> FAMILY HRA <input type="checkbox"/> INDIVIDUAL HRA		
II. SPOUSE INFORMATION					
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
MEDICARE NUMBER & EFFECTIVE DATE (IF APPLICABLE)		DISABLED <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF DISABILITY	
III. DEPENDENT INFORMATION					
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER (REQUIRED)	DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
IV. ADDITIONAL INFORMATION					
ARE ANY OF YOUR DEPENDENT(S) DISABLED?	LIST NAME(S) OF DISABLED DEPENDENT(S)		MEDICARE NUMBER(S) & EFFECTIVE DATE(S) (IF APPLICABLE)		
DO YOU OR YOUR SPOUSE/DEPENDENT(S) HAVE OTHER HEALTH COVERAGE?	LIST NAME OF ENROLLEE AND MEMBERS ENROLLED IN THE PLAN		NAME OF CARRIER & POLICY NUMBER		
V. AUTHORIZATION TO ENROLL IN PLAN OR WAIVE COVERAGE (check waive if applicable and approve with signature)					
<input type="checkbox"/> I WILL WAIVE THE COVERAGE FOR IBEW Local 43 HEALTH PLANS	SIGNATURE			DATE	
	PRINT NAME				

Any person who knowingly presents false or fraudulent information or files a claim containing any materially false information is committing a crime and may be subject to civil and criminal penalties.