NECA-IBEW WELFARE TRUST FUND

SPOUSAL & DEPENDENT INSURANCE FORM

Date _____

YOUR EMPLOYEE _____

Social Security # _____

OUR Member _____

Social Security/ID# _____

Please have the employer complete the following information and return back to the Fund office.

Employer: _____ Address: _____ Phone: _____

Does the employer offer any health insurance regardless of the number of hours the employee works? YES ___NO ___ Did they enroll? _____

Hire Date _____ Full Time _____ Part Time _____ PRN _____

Offered only if a FULL TIME employee? YES___NO___ or offered only at hire? YES___ NO___ or enroll at enrollment period? YES___NO___

When is the next opportunity to enroll in a **comprehensive health benefit plan**? _____

*IS THE POLICY: **MAJOR MEDICAL** _____ **; PRIVATE** _____ **; H.S.A.** _____ **; H.R.A.** _____

Does the policy follow the birthday rule? YES___ NO___ Is the policy for: **family** YES___ NO___ or **single** coverage? YES___ NO___

DEPENDENTS COVERED: _____

What is the original effective date for: **HMO**_____ **PPO** _____

MEDICAL INSURANCE EFF: _____ RX: _____ TERMINATION DATE: _____

Name of carrier: _____ Address: _____

ID#: _____ Group #: _____ Phone #: _____

VISION INSURANCE EFF: _____ TERMINATION DATE: _____

Name of carrier: _____ Address: _____

ID#: _____ Group #: _____ Phone #: _____

DENTAL INSURANCE EFF: _____ TERMINATION DATE: _____

ORTHODONTIA COVERAGE EFF: _____ TERMINATION DATE: _____

Name of carrier: _____ Address: _____

ID#: _____ Group #: _____ Phone #: _____

COMMENTS: _____

_____

Please sign and return this form to our office at your earliest convenience.

_____ _____ _____

Signature of HR/Benefits or Employer — Phone Number — Date completed

Title of person completing form

ITEMS MAY BE FAXED OR MAILED BACK TO:
217.875.2581
NECA-IBEW
2120 HUBBARD AVE.
DECATUR, IL 62526

REVISED 10/11/13