



# Eighth District Electrical Fringe Benefit Funds

## ENROLLMENT FORM (BASIC PLAN)

CHECK ALL THAT APPLY:  New Enrollment  Adding Dependents  Plan Change  Address Change

EMPLOYEE'S FULL LEGAL NAME: \_\_\_\_\_ SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ GENDER: (Mark One) Male \_\_\_\_\_ Female \_\_\_\_\_

PHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ EMAIL: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ DATE OF HIRE: \_\_\_\_\_ LOCAL UNION #: \_\_\_\_\_

| <u>MEDICAL PLAN (Provided By):</u> | <u>PRESCRIPTION (Provided By):</u> | <u>LIFE INSURANCE (Provided By):</u> |
|------------------------------------|------------------------------------|--------------------------------------|
| CIGNA                              | SAV-RX                             | SELF FUNDED                          |

NOTE: IF YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

**DEPENDENTS - (Including Spouse) ADDITIONAL FEE \$638.00**  
**(MUST MAIL IN PAYMENT WITH ENROLLMENT FORM IF ADDING DEPENDENTS)**  
**YOU MUST ATTACH LEGAL DOCUMENTATION THAT APPLIES TO ADD YOUR DEPENDENTS:**  
*Birth Certificate(s) for children, Marriage Certificate for spouse, Legal Adoption papers, Legal Guardianship papers*

| FULL NAME | RELATIONSHIP | DATE OF BIRTH | SSN | GENDER |
|-----------|--------------|---------------|-----|--------|
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|           |              |               |     |        |

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

**MEMBER SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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