



Bricklayers & Allied Craftworkers Local 9 Welfare Fund of Western PA  
 PO Box 160  
 Troy, MI 40899-0160  
 Phone: (412) 317-6538 or Toll Free: (877) 270-1199  
 www.BACLocal9Benefits.org

## VITAL INFORMATION FORM

Email Completed Documentation: [enrollmentdocs@benesys.com](mailto:enrollmentdocs@benesys.com)

New Hire Enrollment                       Adding Dependent(s)                       Demographic Change(s)

**MEMBER Information:** (Please Print)

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_\_ Cell/Home \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: (circle one) Male Female

Marital Status: (circle one) Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: \_\_\_\_\_

Current Status: (circle one) Active Retired Disabled COBRA

Email Address: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

**Medicare Claim Number:** (This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)

	<b>Dependent #</b>	
<b>Member #</b> _____	<b>Spouse #</b> _____	<b>&amp; Name</b> _____

**DEPENDENTS: - Include Spouse** (If additional space is needed, please use 2<sup>nd</sup> sheet, be sure to include marriage certificate and birth certificates, please see dependent coverage letter)

FULL NAME	RELATION	BIRTH-DATE	SOCIAL SECURITY NUMBER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*\*\*Dependent children will remain eligible until the age of 26.*

**BENEFICIARY(ies): (Death Benefits-Medical)**

**If a minor is named as beneficiary, insurance proceeds can only be paid to a legally appointed/qualified guardian.**

NAME	RELATION	BIRTHDAY	S.S. #	ADDRESS/CITY/STATE/ZIP	%
_____	_____	____/____/____	____-____-____	_____	_____
(Primary)					
_____	_____	____/____/____	____-____-____	_____	_____
(Secondary)					
_____	_____	____/____/____	____-____-____	_____	_____

*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, including retroactively cancelling my coverage.*

\_\_\_\_\_  
MEMBER SIGNATURE

\_\_\_\_\_  
Date

**(OVER)**

## OTHER INSURANCE INQUIRY

Signature Required Below

*Please complete this portion of the form if you, your spouse, or any of your dependents have other insurance coverage that you participate in, or if there has been any change in other insurance coverage.*

### **General Information:**

Name of Other Insured Person: \_\_\_\_\_

Other Insured Person Date of Birth: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

### **Information about Other Insurance Plan or Program:**

Other Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insurance Co. Phone #: (\_\_\_\_\_) \_\_\_\_\_

Policy/Group Number: \_\_\_\_\_

Effective date of coverage: \_\_\_\_\_ Is insurance active? \_\_\_\_\_

Termination date if applicable: \_\_\_\_\_

Coverage is: (circle one)      Single      Family

Children are covered until age: \_\_\_\_\_

Type of coverage: (circle all that apply)      Medical      Dental      Vision      Prescription

List covered dependents: \_\_\_\_\_

Coverage provides minimum value under the PPACA: (circle one)      Yes      No

### **Member Statement:**

*The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.*

*I understand that if I make a false statement or materially misrepresent the information on this form, my coverage may be retroactively cancelled. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of any acts of fraud or material misrepresentation.*

**I Have No Other Insurance (Initial):** \_\_\_\_\_

**Member Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_