Local No. 9, IBEW and Outside Contractors Health and Welfare Fund

Annual Information Survey and Confirmation of Other Medical Coverage

YOU MUST COMPLETE THIS FORM EACH YEAR - You must supply ALL info requested - *Your claims will be denied until this form is completed*

Member Information

Would you like to receive plan updates via email? ☐ Yes! ☐ No thanks

NAME (FIRST, MIDDLE, LAST) (MAIDEN)

SOCIAL SECURITY NUMBER	Member's Class 2 BWL # BWL	DATE OF BIRTH (MONTH / DAY / YEAR)
STREET ADDRESS	CITY STATE ZIP	
EMAIL	HOME PHONE include area code	MOBILE PHONE include area code

MARITAL STATUS Check one:	☐ Single	☐ Married Date: Month / Day / Year	☐ Divorced Date: Month / Day / Year	☐ Widowed Date Month / Day / Year

IS MEMBER ON MEDICARE? ☐ Yes ☐ No	If yes, Medicare Claim No.

If yes, Medicare Part **A** effective date	If yes, Medicare Part **B** effective date	If yes, Medicare Part **C** effective date	If yes, Medicare Part **D** effective date

DOES MEMBER HAVE HEALTH CARE COVERAGE UNDER **ANY** OTHER PLAN, **INCLUDING ANY MEDICARE SUPPLEMENT**? ☐ Yes ☐ No If yes, complete the rest of this section

NAME OF PLAN	POLICYHOLDER'S NAME	POLICYHOLDER'S ID NUMBER
GROUP OR PLAN NUMBER	TYPE OF COVERAGE IN THIS PLAN (check all that apply): ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ DRUG	

I hereby confirm that the information provided on this form is true and correct:

MEMBER SIGNATURE DATE

Return this form to Local 9, IBEW and Outside Contractors Health and Welfare Fund, 4415 W Harrison St, Ste 324, Hillside IL 60162. Direct inquiries to 866-661-1021, option 2.

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