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

Special Adult Dependent Enrollment Form

IBEW9 MSECA Partners for Progress

Member Information

NAME (FIRST, MIDDLE, LAST) (MAIDEN)

SOCIAL SECURITY NUMBER | BCBS ID NO. on Member's BCBS card | DATE OF BIRTH (MONTH / DAY / YEAR)

STREET ADDRESS | CITY | STATE | ZIP

EMAIL | HOME PHONE include area code | MOBILE PHONE include area code

Child 1

NAME (FIRST, MIDDLE, LAST) | SOCIAL SECURITY NUMBER

DATE OF BIRTH (MONTH / DAY / YEAR) | MAILING INFORMATION ☐ Check here if mailing address is the same as the Member's mailing address. If different, please provide below.

STREET ADDRESS | CITY | STATE | ZIP

EMAIL | HOME PHONE include area code | MOBILE PHONE include area code

MARITAL STATUS Check one: ☐ Single ☐ Married | DOES CHILD HAVE HEALTH CARE COVERAGE UNDER **ANY** OTHER PLAN, **INCLUDING THE NON-MEMBER PARENT, THE CHILD'S EMPLOYER, SPOUSE OR DOMESTIC PARTNER, OR 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

PHONE NUMBER | CLAIM MAILING ADDRESS

IS CHILD ON MEDICARE? ☐ Yes ☐ No | 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

Child 2

NAME (FIRST, MIDDLE, LAST) | SOCIAL SECURITY NUMBER

DATE OF BIRTH (MONTH / DAY / YEAR) | MAILING INFORMATION ☐ Check here if mailing address is the same as the Member's mailing address. If different, please provide below.

STREET ADDRESS | CITY | STATE | ZIP

EMAIL | HOME PHONE include area code | MOBILE PHONE include area code

MARITAL STATUS Check one: ☐ Single ☐ Married | DOES CHILD HAVE HEALTH CARE COVERAGE UNDER **ANY** OTHER PLAN, **INCLUDING THE NON-MEMBER PARENT, THE CHILD'S EMPLOYER, SPOUSE OR DOMESTIC PARTNER, OR 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

PHONE NUMBER | CLAIM MAILING ADDRESS

IS CHILD ON MEDICARE? ☐ Yes ☐ No | 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

MEMBER SIGNATURE **DATE**

If the child has never been covered under the Plan before, an ORIGINAL or COURT-CERTIFIED COPY of the child's state- or county-issued birth certificate must be provided. The certificate must show the Member as the parent.

Please call 708-449-9004 if you have any questions regarding Special Adult Dependent Enrollment.

Your Funds. Your Foundation. Your Future.

Return this form to: IBEW9OC Welfare Fund
18670 Graphics Drive, Suite 201
Tinley Park IL 60477