IRON WORKERS ST. LOUIS DISTRICT COUNCIL
HEALTH & WELFARE TRUST FUND
PO Box 1096
Maryland Heights, MO 63043
(314) 656-1091 or (877) 597-8704
Fax: (314) 338-3209

VITAL INFORMATION FORM

PARTICIPANT INFORMATION *(PLEASE PRINT)*

Last:_____ First: _____ Middle: ___ Local No.:_____

Address:_____

City: _____ State:_____ ZIP Code:_____

Email Address:_____

Social Security Number: _____ Phone Number: _____
(include area code)

Date of Birth: _____ Gender: *(please circle one)* Male Female
month/day/year

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

Date of Marriage/Divorce/Separation: _____
month/day/year

Current Status: *(please circle one)* Active Retired Disabled COBRA Surviving Spouse

Medicare Claim Number including the letter(s) that follows the number
(This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)

Member # _____ **Spouse #** _____ **Dependent # and Name** _____

DEPENDENT - (Spouse)

FULL NAME	BIRTH DATE	SOCIAL SECURITY NUMBER
_____	_____	_____

DEPENDENT - (Children, indicate if a child is a step-child or if the child does not reside with you)

FULL NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Complete for each step child and each child not born of your current marriage that you want to cover as a dependent.

Child's Name		
Relationship to Employee		
Name of Parent (and step-parent) with Custody		
	Other Natural Parent	Step Parent Other than Employee's Spouse
Name		
Address		
Social Security Number		
Employer's Name		
Employer's Address		
Insurance Company Name		
Address		
Policy Number		

Children whose coverage ended, or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before attainment of age 26 are now eligible to enroll in the Health & Welfare Fund. Participants may request enrollment for such children by completing Section D of this form and returning it to the Fund Office. Enrollment will be effective on the first day of the month in which this completed form is received by the Fund Office. For more information, contact the Fund Office at (877) 597-8704.

Adult Child Certification for Enrollment:

The participant **must certify** that the adult child(ren) being enrolled meets the following age requirement:

☐ **The Adult Child is currently under 26 years of age;**

THE HEALTH & WELFARE FUND'S COVERAGE OF AN ADULT CHILD WILL AUTOMATICALLY END THE LAST DAY OF THE MONTH IN WHICH THE ADULT CHILDTURNS AGE 26.

COORDINATION OF BENEFITS INQUIRY

A. General Information

Participant's Name:_____ Participant's SS#_____

Spouse's Name: _____ Spouse's D.O.B. _____

B. Spouse Employment Information:

Is Spouse employed? YES _____ NO _____ (If no, please skip to section D)

Does Spouse have insurance coverage through employer? YES _____ NO _____
(*If yes, this section must be completed)*.

Spouse's Employer: _____

Employer's Address & Phone #:_____

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) Single Family

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

List covered dependents:

_____ _____
_____ _____
_____ _____
_____ _____

C. Dependent(s) Employment Information: please provide information for each Dependent

Is Dependent(s) employed? YES_____ NO _____
Is Dependent married? YES_____ NO _____

Does Dependent(s) have insurance coverage through employer or spouse's employer? YES _____ NO _____
(*If yes, this section must be completed).*

Dependent or Spouse's Employer: _____

Employer's Address & Phone #: _____

Other Insurance Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Insurance Co. Phone #: (____) _____

Policy/Group Number: _____

Effective Date of Coverage: _____ Is Insurance Active: YES_____NO _____

Termination Date, if applicable: _____

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

D. Member Statement:

I agree to notify the Fund Office within 60 days of any changes to the above information. Further, I declare all the above information to true and accurate to the best of my knowledge and belief. I understand that stating fraudulent, false or misleading information or the omission of material information could be grounds for denial of benefits or the immediate institution of legal action for the recoupment of benefits should benefits have already been paid Any materials submitted by myself or on behalf of any eligible person that contain a material alteration or forged or false information, including signatures, will be rejected. 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 such material in any matter.

I have read the information describing the special enrollment opportunity and understand the participation conditions and requirements. By signing below, I certify that: ***1)*** *the information provided above is correct;* ***2)*** *All adult child coverage is contingent upon me maintaining my eligibility as defined by the Plan Document; and* ***3)*** *I will be financially responsible for any claims paid for ineligible adult children if the claims were paid based upon inaccurate or misleading information I have provided above.*

Participant's Signature: _____ **Date:** _____