NATIONAL EMPLOYEES HEALTH PLAN

VITAL INFORMATION FORM

Last: _____ First: _____ Middle: _____

Address/City/State/Zip: _____

Social Security Number: ____-____-____ Date of Birth: ____/____/____ Gender :(*circle one*) Male Female

Telephone Number: (____) _____ Alternate Phone Number: (_____) _____

Email Address: _____

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

Date of Marriage/Divorce/Separation: _____

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

Employer Name: _____ Job Title: _____

Home Local: _____ Home Fund: _____ Initiation Date: _____

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** _____

DEPENDENTS: - Include Spouse (***Marriage/Birth Certificates are needed to add any new dependents to the plan)***

FULL NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH

BENEFICIARY INFORMATION:

NAME	RELATION	SS #	BIRTHDAY	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.

_____ _____

MEMBER SIGNATURE **Date** **(OVER)**

OTHER INSURANCE INQUIRY

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: _____

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.

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 No Other Insurance: _____
Initial Here/Sign Below

Member Signature:_____ **Date:** _____