



Steubenville Electrical Welfare Fund  
 PO Box 364  
 Troy, MI 48099  
 (330) 779-8889  
 www.ibew246benefits.org

## VITAL INFORMATION FORM

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

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

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 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

Home Local: \_\_\_\_\_ Home Fund: \_\_\_\_\_ UBC# \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ Alternate Phone Number: (\_\_\_\_\_) \_\_\_\_\_

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

Employer \_\_\_\_\_ 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)*

**Dependent #**

Member # \_\_\_\_\_ Spouse # \_\_\_\_\_ 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 \_\_\_\_\_

## 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:** \_\_\_\_\_