# IBEW LOCAL 910 WELFARE FUND
# GROUP BENEFIT ENROLLMENT/CHANGE FORM

| PARTICIPANT NAME (FIRST NAME + MI + LAST NAME) | SOCIAL SECURITY # | DATE OF BIRTH | | SEX (CIRCLE ONE)<br>M F |
|---|---|---|---|---|
| MAILING ADDRESS (STREET, APT NO.) | CITY | STATE | ZIP CODE | |
| EMAIL ADDRESS | TELEPHONE # | MARITAL STATUS (CHECK ONE)<br>_____SINGLE _____MARRIED _____DIVORCED | | |

**IN WHICH PLAN TYPE & COVERAGE AMOUNT ARE YOU ENROLLING?**

| ACTIVE MEMBER | RETIREE MEMBER | RETIREE – MEDICARE ELIGIBLE MEMBER |
|---|---|---|
| _____INDIVIDUAL _____FAMILY<br>_____HRA ONLY/OPT OUT* | _____INDIVIDUAL _____FAMILY<br>_____HRA ONLY/OPT OUT* | _____INDIVIDUAL _____FAMILY<br>_____HRA ONLY/OPT OUT* |

*If electing to OPT OUT, you must complete the Waiver of Participation Form and provide proof of insurance.

**INFORMATION ABOUT FAMILY PARTICIPANTS YOU WANT ENROLLED UNDER YOUR PLAN:** (for additional dependents attach another page; Proof of Marriage and Birth Certificates are required if adding spouse or dependent child(ren) and tax filings or court orders for stepchild(ren).

| NAME (FIRST NAME + MI + LAST NAME) | SOCIAL SECURITY # | DATE OF BIRTH | SEX |
|---|---|---|---|
| SPOUSE: | | | |
| DEPENDENT: | | | |
| DEPENDENT: | | | |
| DEPENDENT: | | | |
| DEPENDENT: | | | |
| DEPENDENT: | | | |
| DEPENDENT: | | | |

*I hereby certify that the above information is correct. I further certify that I have read and agree to these Terms and Conditions*: I, the above-named participant, hereby authorize the elected benefit premiums noted above until such time as I should provide written notice to change or discontinue these deductions. I also authorize the Plan Administrator to make any future adjustments necessary should there be a change in the premium amounts for the coverage option I have selected. I agree to notify the Plan Administrator in writing of any changes to my personal information above that may affect the administration of my benefits. I understand that neither my employer nor the Plan Administrator will be held liable for any delays or problems in the administration of my Plan or issue of my reimbursements, in the event that I fail to provide them with this information in an accurate and timely manner. I agree to be responsible for paying any fees associated with having the Plan Administrator reissue reimbursement checks to me in the event that the initial payments issued to me are lost, stolen, misplaced or otherwise not received by me in a timely manner. By signing this enrollment form, I agree to have the amount of any over-reimbursed prescription claim deducted automatically from my HRA if my prescription coverage pays for a claim after my coverage, or the coverage of my spouse or dependent, has ended.

_______________________________ PARTICIPANT'S SIGNATURE

_______________________________ DATE

**TO BE COMPLETED BY IBEW LOCAL 910 FUND OFFICE:**

Eligibility Date: _______________ Effective Date: _______________ Date Received: _______________