

LABORERS' NATIONAL HEALTH AND WELFARE FUND

5565 Sterrett Place, Suite 210
Columbia, MD 21044
800-235-5805

ENROLLMENT / COORDINATION OF BENEFITS AND DEPENDANT STATUS STATEMENT

Must be completed in its entirety by all participants of the Laborers' National Health and Welfare Fund. Payment of pending and /or future claims will be considered upon receipt of this completed form. If this form is not on file at the Fund Office claims may not be paid.

PARTICIPANT BASIC ENROLLMENT INFORMATION

(please type or print)

Participant's Name: _____ Birth Date: _____
(Last) (First) (MI)

Street Address: _____ City/State: _____ Zip: _____

Sex: _____ Soc. Sec. No: _____ Telephone No.: _____ Local Union # _____

MARITAL STATUS (Circle One): Married Single Divorced Separated Widowed

CERTIFICATION OF DEPENDENT ELIGIBILITY

Are you seeking Coverage under the Plan for any Dependent? ____ Yes ____ No

IF YES, YOU **MUST** COMPLETE ALL APPLICABLE SECTIONS OF THIS FORM:

➤ **SPOUSE INFORMATION**

Name: _____ Soc. Sec. No: _____

Birth Date: _____ Sex: _____ Date of Marriage: _____

Employer's Name: _____ Address: _____

➤ **CHILD(REN):** List below names of your unmarried dependent children under age 19, or 23 if a full time student in school, who depend upon you for support:

Name (first, last)	Birth date	Soc. Sec. #	Relationship

IF APPLICABLE CHANGES HAVE OCCURRED, YOU MUST ATTACH A COPY OF YOUR MARRIAGE CERTIFICATE, CHILDREN'S BIRTH CERTIFICATE AND, PROOF OF STATUS AS FULL-TIME STUDENT

***LIFE INSURANCE** - **DESIGNATION OF BENEFICIARY/ BENEFICIARES**

I hereby designate as my Beneficiary/Beneficiaries to receive any benefits, payable at my death from the Laborers' National Health and Welfare Fund:

Name: _____ Soc. Sec. #: _____ Relationship: _____ Birth Date: _____

Name: _____ Soc. Sec. #: _____ Relationship: _____ Birth Date: _____

Address: _____

CERTIFICATION REGARDING SECONDARY INSURANCE COVERAGE

In addition to your coverage under the Laborers' National Health & Welfare Fund, are you, your spouse or dependent children covered by another health plan? This includes Medicare, Blue Cross-Blue Shield, HMO Plans, PPO Plans, etc.

_____ yes _____ no

IF YES, YOU MUST PROVIDE ALL OF THE FOLLOWING INFORMATION:

OTHER HEALTH INSURANCE (If multiple coverage exists, please list on a separate sheet of paper)

Covered Person's Name: _____ Policy No.: _____

Covered Person's Relationship to You: _____

Name of other health plan: _____

Address of other health plan: _____

Effective Date of Coverage: _____

Is coverage through an Employer or Other Group? _____ yes _____ no

If yes, Name of Employer or Other Group: _____

SERVICES COVERED - The other health plan covers the following services:

Medical Benefits _____ yes _____ no

Dental Benefits _____ yes _____ no

Vision Benefits _____ yes _____ no

Prescription Benefits _____ yes _____ no

PLEASE READ CAREFULLY AND SIGN BELOW

I hereby certify that the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentionally falsify any of the above information, Medical claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of any change.

Member's Signature _____

Date _____

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