



**Laborers' National
Health & Welfare Fund**

905 16th NW, Suite 300
Washington, DC 20006-1765
www.lnhwf.org

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. If this form is not on file at the Fund Office claims may not be paid.

PARTICIPANT BASIC ENROLLMENT INFORMATION

(please type or print) _____ E-Mail Address _____

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

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 26 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.**

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

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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