Laborers' National
Health & Welfare Fund

905 16st 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** **Window**

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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