# PLUMBERS AND STEAMFITTERS LOCAL UNION NO. 43 HEALTH AND WELFARE FUND

Administered by Southern Benefit Administrators, Incorporated


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## ENROLLMENT FORM

**Please complete this form in its entirety, front and back and return it in the enclosed envelope**. The information requested below is very important as it provides the Fund office with current information about you and your dependents. Please only list those dependents who meet the definition of an Eligible Dependent, as that term is defined in your Summary Plan Description. Please sign and date the form.

The "Patient Protection and Affordable Care Act", a health care reform bill enacted by Congress and signed into law by the President in March 2010, provides that group health plans that cover dependent children must extend coverage for such dependents until attainment of age 26. In addition, a dependent child may not be excluded based on the following criteria: financial dependency, residency, student status, marital status, employment or eligibility for other coverage. **By completing and signing this form, you are certifying that you wish to apply for coverage for the dependents named below.**

### INFORMATION REGARDING YOU AND YOUR DEPENDENTS

Participant Name:_____ Date of Birth: _____Sex:_____

Address:_____City:_____State: _____

Zip Code:_____ Social Security No:_____ Local Union No._____

Participant's Email Address:_____ Phone Number:_____

Spouse's Email Address: _____Phone Number:_____

Spouse's Name:_____Date of Birth: _____Sex:_____

Spouse's Social Security No.:_____ Date of Marriage:_____

Dependent Children:

| Names: | Birthdate: | Social Security Number: | Relationship: | Sex: |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

**IF YOU OR A DEPENDENT HAVE OTHER HEALTH COVERAGE, COMPLETE THIS SECTION**

Name of Covered Individual:_____

Group No:_____ Contract No.:_____

Name/Address of Insurance Company or Plan:_____

Telephone number of Insurance Company or Plan:_____

Effective date of coverage_____ Termination date of coverage (if applicable)_____

Type of coverage:_____Single _____ Family

_____ Medical _____ Dental _____ RX _____ Vision

Is your other coverage PPO or HMO? _____

**IF YOU OR A DEPENDENT HAVE MEDICARE COVERAGE, COMPLETE THIS SECTION**

Name of Covered Individual:_____

Medicare Health Insurance (HIC) Number:_____

Enrolled in:_____ Part A _____ Part B _____ Part D

Medicare Eligibility based on: _____ Age _____ Disability _____ End Stage Renal Disease

**Signature:_____ Date:_____**

## THIS FORM MUST BE SIGNED AND DATED BY THE PARTICIPANT