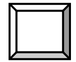
IBEW LOCAL 683 HEALTH and WELFARE FUND
PARTICIPANT'S ENROLLMENT/UPDATE CARD

IF YOU ARE ADDING A DEPENDENT NOT PREVIOUSLY ENROLLED, PLEASE CHECK THIS BOX 

FUND PARTICIPANT'S INFORMATION **Local:** ________________

Classification : ______ **Inside Wireman** ______ **Teledata** _______ **CE/CW** ______ **Office and Salary**

Participant's Name: ____

Participant's Social Security Number: _________________________ Date of Birth: ____________________________
Month/Day/Year

Participant's Home Address: ____
Address Apt. #

____
City State Zip Code

Participant's Home Telephone Number: ________________ Participant's Cell Phone Number: __________________

Participant's Sex: Male/Female (Circle One) Participant's Marital Status: Single/Married/Legally Separated/Divorced/Widowed (Circle One)

PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING YOUR SPOUSE:

Spouse's Name: ________________________________ Spouse's Social Security Number: _________________________

Date of Birth: __________________________________
Month/Day/Year

If your spouse is employed, please provide the complete name, address and phone number of his/her employer:

____
Name Address City/State/Zip Code Telephone Number

PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING YOUR DEPENDENT CHILDREN:

Complete the following information on **ALL** children less than 26 years of age which you are claiming as eligible dependents.

Full Name	Date of Birth	Male or Female	Stepchild (Y/N)	Social Security Number

Medicare Information:

Name/Medicare Number/Effective Date ____

Name/Medicare Number/Effective Date ____

I/We jointly certify that the information on the reverse side of this form is true and correct.

I/We hereby acknowledge that by participating in the IBEW Local 683 Health and Welfare Fund, I/We understand that the Fund may receive, use, and disclose Personal Health Information from/to doctors, pharmacists, hospitals, and other entities for the purpose of facilitating payment, treatment, and plan administration and operation. I/We also understand that the Fund may receive information from any Union, other Trust Fund, Employer, or other entity for determining eligibility for benefits and to verify my address. This acknowledgement applies equally to our dependent children.

Participant Signature and Date: ____

Spouse signature and Date: ____

(Complete Other Side)

OTHER INSURANCE/COVERAGE:

Are you, your Spouse, or children enrolled in any other employer-based insurance plan (Group Plan? ____ Yes ____ No
Are you, your spouse or children enrolled in Medicare or Medicaid? ____ Yes ____ No
If you answered **Yes** to any of the above questions, please complete the following:
Group Medical Carrier Name__________________________________ Initial Effective Date: ____________________
Insured's Name (Employee) ____
Names of Dependents covered ____
Medical Policy/Identification Number and Group Number: ____
Prescription Coverage ___ Yes ___ No

Group Dental Carrier Name__________________________________ Initial Effective Date: ____________________
Insured's Name (Employee) ___________ ____
Names of Dependents covered ____
Dental Policy/Identification Number and Group Number: ____

If more than one family member has other coverage, please complete the information on a separate piece of paper.

OPTIONAL AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION (PHI)

I/We authorize the Fund to provide information to any Union, other Trust Fund, Employer, or Insurance Carrier related to determining eligibility for benefits to which I/we may be entitled.

I/We authorize the IBEW Local 683 Welfare Fund to release information to and to discuss with the person designated below as my/our personal representative(s) the status and substance of claims and appeals related to benefits to which I/we may be entitled from the Fund for the purpose of obtaining or facilitating treatment and payment of those benefits.

Participant's Personal Representative: ____ (Name and relationship).

I agree to be Participant's Personal Representative: ________________________________ (Signature of person above).

Spouse's Personal Representative: ____ (Name and relationship).

I agree to be Spouse's Personal Representative: ____________________________________ (Signature of person above).

I/We understand that: (1) this authorization shall remain in effect for one year from the date signed unless revoked or limited in writing prior to that date; (2) I/we have the right to revoke or limit the above authorization at any time; and (3) the Fund cannot, and will not, condition payment, enrollment, or eligibility for benefits on my decision to sign this authorization. **(I/we understand, however, that if I/we have not certified the enrollment information pertaining to dependents and other insurance/coverage then benefits may be limited).** I/We further understand that use and disclosure of personal health information may be limited by law in certain circumstances and that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and then may no longer be protected by laws that limit the Fund's disclosure of use of the information.

I/We have informed my/our eligible dependent(s), other than my spouse, that the Fund will presume that I and the natural parent(s) of dependent children are authorized to receive, use and discuss personal health information on behalf of said dependent children to the extent allowed by law unless informed otherwise in writing by, or on behalf of, said child.

Participant Signature and Date: ____
Spouse signature and Date: ____

(Complete Other Side)