IBT LOCAL 145 HEALTH SERVICES AND INSURANCE PLAN

2505 Main St., Ste. 233, Stratford, CT 06615 ---- Ph: 203-375-6088 – Fax: 203-375-6106

Union Trustees: Dennis Novak and Italo Bonacci Employer Trustees: Sheila Nevins and OJ DeChristofano

NEW ENROLLMENT and CHANGE IN FAMILY STATUS FORM

NEW ENROLLMENT..............☐ or **CHANGE...............☐**

EFFECTIVE DATE IF CHANGE ________/______/_________

EMPLOYEE INFORMATION – Complete this section at all times

Last Name ____ **First Name**______________________________________ **MI** ______

Address____ **City** ____________________________**State**_____**Zip**__________

Soc.Sec.No. __________-________-________ **Date of Birth** _________/_______/________ **Daytime Phone # (**_____**)**_______________

Email Address: ____ **Male** ○ **Female** ○ **Married** ○ **Single** ○

Hire Date ________/______/_______ **Name of your Employer**___________________________

DEPENDENT INFORMATION

Before we consider you or your family eligible for benefits you must provide the appropriate information and/or documentation: (check all that apply)

1. Marriage Certificate ☐ or Divorce Decree ☐ or Loss of Spouse/Other Coverage ☐
2. Birth Certificate for any children, stating the names of the natural Father & Mother ☐
3. Other Insurance Coverage Inquiry:

   Does your spouse have insurance through his/her employer? ☐ Yes ☐ No

   If yes, when did coverage begin? ________/_______/________

   If yes, provide Name and Address of Employer ____

   Name of Insurance Provider/Carrier ____

   If yes, what type of coverage does your spouse have? ☐Family/Group or ☐ Individual

   If yes, what coverage ☐ Medical ☐ Prescription ☐ Dental ☐ Vision
4. Loss of Spouse or Other Dependent Coverage, Name ______________ ☐ When did coverage end? ______/_____/______

In the section below, list the name of your eligible spouse and/or children. If add'l space is needed, check here☐ and continue adding on back or attach other another form.

If you are deleting a dependent, please state reason: ____

NAME (Last,First, MI)	SocSecNo (required)	Relationship to You	Birthdate	
	_ _	Spouse ○ Son ○ Daughter ○ Other ○___________	/ /	○ Add ○Delete Eff Date: __________
	_ _	Spouse ○ Son ○ Daughter ○ Other ○___________	/ /	○ Add ○Delete Eff Date: __________
	_ _	Spouse ○ Son ○ Daughter ○ Other ○___________	/ /	○ Add ○Delete Eff Date: __________
	_ _	Spouse ○ Son ○ Daughter ○ Other ○___________	/ /	○ Add ○Delete Eff Date: __________
	_ _	Spouse ○ Son ○ Daughter ○ Other ○___________	/ /	○ Add ○Delete Eff Date: __________
	_ _	Spouse ○ Son ○ Daughter ○ Other ○___________	/ /	○ Add ○Delete Eff Date: __________

Please review your Summary Plan Description for the eligible qualified dependent description. You are responsible for notifying the Company of any changes in your family status.

Employee Signature _______________________________________ **Today's Date** ________________