ENROLLMENT FORM

Return form to:

10003 Derekwood Ln, Ste. 130
Lanham, MD 20706-4811

Electrical Welfare Trust Fund • Electrical Workers Local No. 26 Pension Trust Fund • Electrical Workers Local No. 26 Individual Account Plan • Local Labor Management Cooperation Committee

This information is to be completed by the **person working under the jurisdiction of IBEW Local 26**. You are required to notify the Fund Office of any changes in your address, marital status, dependent information or other insurance information.

Is this a new address ☐ Y ☐ N, telephone number ☐ Y ☐ N, email address ☐ Y ☐ N, or all new info ☐ Y ☐ N?

Part 1 – Your Information

Last Name	First Name	Initial
Street Address	City & State	Zip Code

Phone Number (include area code) Home Cell	Your Email Address

Social Security Number	Date of Birth	Gender Male Female

Part 2 – Spouse Information

Name	Gender Male Female	Date of Birth

Date of Marriage (Attach Copy of Marriage Certificate)	Spouse's Social Security Number*

Part 3 – Dependent Children

Full Name of Child (Last, First, Middle Initial)	Child's SSN* (If child is a newborn, submit copy of card at your earliest convenience.)	Relationship to Participant (son, daughter, stepson/daughter)	Date of Birth (attach copy of birth certificate)

* If not received within 6 months from the date of birth, the date of marriage or the date added, the spouse and/or dependent's coverage will terminate.

The back of this form refers to other insurance coverage for the participant, spouse and dependent children. If the back of this form is not signed and dated, it is incomplete. If you do not answer the questions on the back of this form, your spouse and/or dependent children will not be added. You will be notified of what you need to do to complete the process.

Other Insurance Including Medicare Information

If you or any eligible dependents have coverage with another company, you are required to tell EWTF this information so that a proper determination can be made as to which company is primary. If you do not file with the correct company, then you may liable for any overpayments made to your healthcare providers. You **must** answer each question on this page.

Medicare Coverage	Do you or any family members that you have listed on the front of this form have Medicare coverage? **YES** **NO** (If YES, attach a copy of the front of the card for each person.)
Other Insurance Information (If YES, attach a copy of the front and back of the card for each person.) **If this section is not completed in full, one of two things will occur:** **1.** spouse and/or dependents will not be added to the coverage or **2.** any claims received will not be paid until info regarding other coverage is received. Attach a separate piece of paper if more room is needed.	Do you or any family members that you have listed on the front of this form have any other group health plan other than EWTF? **YES** **NO**

Spouse's Name	Name of Employer	Employer's Telephone Number
Name & Address of Other Coverage Company		Telephone Number
Is this an individual or family plan? (circle one) List the family members on this page (if applicable)	Type of Coverage (check the appropriate coverage) ___Medical ___ Dental ___ Vision ___ Prescription ___ Mental Health incl Substance Abuse ___ Hospitalization ___ All of the Above Effective Date of Coverage: ______________	

Name of Child	Name of Other Group Health Plan Covering Child	Telephone Number
Whose Policy is it and what is the relationship to the child? Policy #:	Type of Coverage (check the appropriate coverage) ___Medical ___ Dental ___ Vision ___ Prescription ___ Mental Health/Substance Abuse ___ Hospitalization ___ All of the Above	Effective Date of Coverage:
Does this Child have Coverage under an Ex-Spouse?	Ex-Spouse's Name	Ex-Spouse Date of Birth
Name of Child	Name of Other Group Health Plan Covering Child	Telephone Number
Whose Policy is it and what is the relationship to the child? Policy #:	Type of Coverage (check the appropriate coverage) ___Medical ___ Dental ___ Vision ___ Prescription ___ Mental Health/Substance Abuse ___ Hospitalization ___ All of the Above	Effective Date of Coverage:
Does this Child have Coverage under an Ex-Spouse?	Ex-Spouse's Name	Ex-Spouse Date of Birth

Participant Signature (person working under Local 26 jurisdiction)	I certify that the information furnished by me to the Electrical Welfare Trust Fund (EWTF) is accurate and complete and that I am responsible for notifying EWTF of any changes in the status or address of listed dependents. I further understand that I am responsible for benefits paid based upon the information that I have furnished and that submitting any claims paid by EWTF based on incorrect information may result in the loss of future benefits and will require repayment of benefits. This is the original document and not a copy. **Signature:** ______________________________ **Date:** ________________