LOCAL 26 IBEW-NECA Joint Trust Funds

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

LIFE EVENT

This form is to be completed by the person working under the jurisdiction of Local 26, IBEW to add a new dependent. You are required to notify the Fund Office of any changes in your address, marital status or dependent information. If more information is required, you will be notified in writing. Upon receipt of complete forms and documents, a letter confirming the addition of your dependent will be mailed to you.

PART I (Participant Information)

Participant's Last Name	First Name	Middle Initial
Street Address	City State	Zip Code
E-mail Address		Telephone Number
Social Security Number	Date of Birth	Gender

PART II (New Dependent Information)

Dependent's Last Name		First Name	Middle Initial
Dependent's Social Security No.*	Dependent's Gender	Dependent's Date of Birth**	If Dependent is your Spouse, your Date of Marriage

Name, Address & Telephone Number of Dependent's Other Insurance Co (Attach copy of front & back of other insurance card)

☐ Check this box if the above dependent does not have any other insurance or health care coverage.

Type of Coverage	Effective Date	Individual or Family Plan
Medical		
Dental		
Vision		
Hospitalization		
Prescription		

* 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 be terminated.

** Submit a copy of the birth certificate or the verification of birth from the medical records department of the hospital.

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 furnishing any benefits paid by EWTF based on incorrect information may result in the loss of future benefits and will require repayment of benefits.

Participant Signature _____ Date _____

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