Roofers Local No.74/Local #203
Health & Welfare
Enrollment Form - 2015

PARTICIPANT

Social Security # _____ Date of Birth _____ Sex ____

Last Name First Name Middle Initial

Address

City State Zip

Area code & Telephone number _____
E-mail address _____

Single ____
Married ____ Date of Marriage _____
Divorced ____ Date of Divorce _____
Separated ____ Date of Separation _____ Do you pay support? _____

SPOUSE INFORMATION

Social Security # _____ Date of Birth _____ Sex ____

Last Name First name Middle Initial

Address

City State Zip

Name of Spouse Employer

Name of Spouse Insurance Carrier (s)_____ Effective Date: _____ Family or Single

Type of Spouse Insurance:			
	Medical	Yes	No
	Prescriptions	Yes	No
	Dental	Yes	No
	Vision	Yes	No
	Disabled	Yes	No
	Entitled to Medicare	Yes	No

DEPENDENTS

Social Security # _____ Date of Birth_____ ___Sex____

_____

Last Name First Name Middle Initial

_____

Address

_____City

State Zip

Disabled Yes No
Entitled to Medicare Yes No

DEPENDENTS

Social Security # _____ Date of Birth_____ ___Sex____

_____

Last Name First Name Middle Initial

_____

Address

_____City

State Zip

Disabled Yes No
Entitled to Medicare Yes No

DEPENDENTS

Social Security # _____ Date of Birth_____ ___Sex____

_____

Last Name First Name Middle Initial

_____

Address

_____City

State Zip

Disabled Yes No
Entitled to Medicare Yes No

"Additional children write on back"

(A)
If you are **Unmarried**, or **Divorced**, the following questions must be answered:
Do you have sole or joint custody of your children?
Yes No

- How many months out of the year _____
- How many days out of the week _____

Do you pay support for your children?
Yes No

- Means of support _____

Do your children reside with you?
Yes No

- If no, Is there a court order stating that you must provide medical coverage for children? Yes No

  If yes, a copy of order must be submitted to the fund office.

- If no, do you have a signed agreement, specifically form 8332 or court order, with the other parent of the dependent allowing you to claim the dependent on your taxes? Yes No

  If yes, please attach a copy of the agreement/court order/income tax form

(B)
If you are **Separated** from your spouse.
Do you pay support to your separated spouse?
Yes No

- If yes, submit proof.

(C)
If you are **Married** and have **Stepchildren**
Do you support the stepchild (stepchildren)?
Yes No

- If yes, submit proof, income tax form, court papers,. etc

Is the stepchild (children) natural estranged parent responsible to provide medical coverage?
Yes No

COORDINATION OF BENEFITS QUESTIONNAIRE

Your health benefit plan includes a coordination of benefits clause that determines the primary source of payment when a member is covered by more than one health insurance policy. The terms of your health benefit plan require you to provide all of the information necessary to properly coordinate your benefit. Failure to provide this information may result in the denial of claims for you or your dependents. The information you provide assists us in the prompt processing of claims.

Employee Name: _____ Employer: _____

ID #: _____ (Alternate ID # can be found on your ID card)

SECTION A: OTHER INSURANCE

Are you or is any member of your family enrolled in any other health or dental insurance program (including Medicaid)?

☐ No – Please go on to Section B
☐ Yes – Please complete the following:

Health Insurance Information (excluding Medicare)

Please provide the details of the other medical/dental coverage (excluding Medicare). If other insurance is Medicare, please go on to Section B.

Name of Policyholder of other coverage: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Is the Policyholder actively employed? ☐ Yes – Employment date: _____
☐ No

Employer name (if applicable): _____

Please provide details of the other Medical coverage:

Health Insurance Company Name, Address and Phone: _____

_____

Policy Number: _____ Effective Date (required): _____ Cancel Date: _____

Type of Contract: ☐ Self ☐ Family - Please list dependents including spouse:

Spouse: _____ Dependent: _____

Dependent: _____ Dependent: _____

Dependent: _____ Dependent: _____

Type of coverage (check all that apply): ☐ Major Medical ☐ Hospital ☐ Drug ☐ Vision

Are you or your spouse enrolled in an IRS-qualified High Deductible Health Plan with a Health Savings Account (HSA)?

☐ Yes
☐ No

Please provide details of the other Dental coverage:

Dental Insurance Company Name, Address and Phone: _____

_____

Policy Number: _____ Effective Date (required): _____ Cancel Date: _____

Type of Contract: ☐ Self ☐ Family - Please list dependents including spouse:

Spouse: _____ Dependent: _____

Dependent: _____ Dependent: _____

Dependent: _____ Dependent: _____

If this coverage is provided for dependent child(ren) whose natural parents are divorced, separated or were never married, it is necessary to attach a copy of the court decree which identifies what parent is responsible for providing health coverage. If the court decree does not specify who is responsible, then it will be necessary to provide a copy of the custody agreement for the dependent child(ren). If you have previously provided the court decree to us, you do not have to provide it again.

SECTION B: MEDICARE RELATED INFORMATION

Medicare Information Only (Please Refer to your Medicare Card)

Are you or any of your dependents eligible for Medicare?
☐ No
☐ Yes – Please complete the following:

Reason(s) for Medicare coverage (check all that apply):
☐ Over age 65
☐ Disabled
☐ End-Stage Renal Disease

Status of Policyholder under this policy:
☐ Actively Employed
☐ Retired – Retirement Date: _____

For You		For Your Dependent	
Name of Beneficiary:		Name of Beneficiary:	
Medicare Claim Number:		Medicare Claim Number:	
Part A effective date:		Part A effective date:	
Part B effective date:		Part B effective date:	
Part D effective date:		Part D effective date:	

I certify that the above information is true and correct. I understand that the purpose of this information is to assure appropriate coordination of benefits of all plans. If any of the above information changes, I will notify the Roofers Fund office.

Signature: _____ Date: _____