Roofers Local 33 Insurance Fund

ENROLLMENT FORM

PLEASE PRINT

(1) Participant's Name _____ _____
Social Security #

(2) Address _____
(no.) (Street) (city/town) (State) (zip)

(3) Date of Birth _____ Phone ( )_____ Sex: M F

(4) Email Address _____

(5) Marital Status: Single ( ) Married ( ) Divorced ( ) Separated ( )
If Married, Date of Marriage _____ * If Divorced, Date of Divorce_____

*If Married, please send in copy of Marriage License
*If Divorced, please send in copy of Divorce decree

(6) Are you, your Spouse or Eligible Dependent(s) covered by any other Health Insurance? YES ( ) NO ( )

(7) If YES, please complete all of the following for our records:
List person (Subscriber) covered by other Insurance_____

Name & Address of Other Insurance Company _____
_____

Name & Address of Employer of person covered by other insurance _____
_____

(8) Group Number of Other Insurance _____ Certificate Number _____

(9) Are you or any Eligible Dependent(s) eligible for MEDICARE Benefits?
If YES, Name of person(s) and please provide details_____

PLEASE COMPLETE THE DEPENDENT INFO. ON REVERSE SIDE OF FORM

PLEASE SIGN AND DATE ON REVERSE SIDE OF FORM

(10) PLEASE LIST THE COMPLETE INFORMATION CONCERNING EACH OF YOUR ELIGIBLE DEPENDENTS: **PLEASE BE SURE TO PROVIDE YOUR DEPENDENTS SOCIAL SECURITY NUMBERS AS IT IS NOW REQUIRED BY CENTER FOR MEDICARE.**

Please provide copies of all <u>dependent children's</u> BIRTH CERTIFICATES

NAME OF DEPENDENT (first) (last)	SS# (REQUIRED)	SEX	SPOUSE	CHILD	STEP CHILD	DATE OF BIRTH
_____	_____	M F	( )	( )	( )	_____
_____	_____	M F	( )	( )	( )	_____
_____	_____	M F	( )	( )	( )	_____
_____	_____	M F	( )	( )	( )	_____
_____	_____	M F	( )	( )	( )	_____
_____	_____	M F	( )	( )	( )	_____

(11) If you named a Step Child as your Eligible Dependent, are you LEGALLY responsible for the Step Child's medical expenses?

YES ( ) NO ( ). If YES, the participants spouse must be listed as parent on birth certificate.

<u>The participant is obligated to notify the fund office of divorce, legal separation or if a dependent becomes eligible for other employer sponsored coverage.</u>

I certify that the statements on this Enrollment Form are true, accurate and complete to the best of my knowledge and understand that incorrect, incomplete or false information provided by me may affect me and my Eligible Dependents qualifying for Health & Welfare Benefits.

_____ _____

Date Signed Participant's Signature

Please use the area below for additional dependent information.