TOLEDO ELECTRICAL WELFARE FUND

2021 ENROLLMENT FORM

419.666.4450 phone | 419.666.5410 fax | enrollment@electricalfunds.org

**PLEASE PRINT AND COMPLETE FORM IN DARK BLUE OR BLACK INK*

New Participant _____ Change/Add _____ **Annual Enrollment _____**

PARTICIPANT (LOCAL 8 MEMBER) INFORMATION *If you are a Surviving Spouse please list your information in this box			
		IBEW CARD#_____	
Full Name:	Birthday:	UID or Full SSN:	
Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Email:	

Circle One:	Circle One:		
Male | Female	Single | Married | Widowed	*If Married*	Divorced: Y / N
		Date of Marriage:	Date of Divorce:

LIST SPOUSE (INCLUDE LAST NAME IF DIFFERENT FROM PARTICIPANT)				
Name	Full SSN:	Birth Date:	Employed? Y / N	Do you have other Health Ins. Primary? * Y / N
Is your spouse Self-Employed? Y / N	Company Name:			
Is your spouse employed by a Local 8 Contractor? Y / N	Contractor Name:	Contractor Phone Number:		

LIST ALL ELIGIBLE DEPENDENTS UNDER ELECTRICIANS TEWF INSURANCE PLAN (INCLUDE LAST NAME IF DIFFERENT FROM ELECTRICIANS)-ATTACH A SEPARATE SHEET IF NEEDED.					
Name	Relationship (Son/Daughter, Stepson/Stepdaughter)	Full SSN	Birth Date	Employed? Yes or No	Does dependent have other Health Insurance?
				Y / N	Y / N
				Y / N	Y / N
				Y / N	Y / N

*****IMPORTANT*****

*If you marked YES to your spouse having other health insurance, fill out this section, provide a copy of the front and back of their insurance card and **complete the enclosed Spousal Eligibility Affidavit form.**		
OTHER HEALTH INSURANCE PRIMARY		
Name of Insured:	Name of Insurance plan/carrier:	Policy #:
		List any Dependents covered under Policy:
Effective Date:	Type of Coverage (Circle all Applicable): Medical | Dental | RX | Vision	

I hereby authorize any physician, hospital, insurer, or other organization or person having any records, data, or information concerning health history or medical insurance for me or my family members to furnish such records, data, or information as may be requested by Toledo Electrical Welfare Fund ("TEWF") or their duly authorized representative. A photocopy of this document shall be considered as effective and valid as the original. I Certify that the dependents listed are my dependents as defined by the TEWF, I agree to notify the Fund office if there is a change in any dependent's status such as divorce, birth of a child, etc. I further realize that failure to disclose other insurance coverage information or to falsify information to the TEWF is considered a fraudulent act against the Fund. A fraudulent act may result in denial of eligibility under the fund.

Signature of Participant (LOCAL 8 MEMBER) _____ Date_____

Please return to: TEWF, PO BOX 60408, ROSSFORD, OH 43460 or email to: enrollment@electricalfunds.org