TOLEDO ELECTRICAL WELFARE FUND

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#_____	
First/Last Name:		Birthday:		UID or Full SSN:	
Address:		City:		State:	Zip Code:
Home Phone:		Cell Phone:	Email:		
Female ☐	Single ☐	Married ☐	Date of Marriage:		
Male ☐	Widowed ☐	Divorced ☐	Date of Divorce:		

SPOUSE INFORMATION

NOTE– A SEPARATE **SPOUSAL AFFIDAVIT FORM** MUST BE INCLUDED REGARDLESS OF SPOUSE'S EMPLOYMENT STATUS				
Spouse's First/Last Name:	Full SSN:	Birth Date: Phone Number:	Employed? Yes ☐ No ☐	Do you have other Health Ins. Primary? *
Is your spouse employed by a Local 8 Contractor?	Local 8 Contractor Name:		Local 8 Contractor Phone Number:	

*If you marked YES to your spouse having other health insurance, fill out this section and provide a copy of the front and back of their insurance card.

OTHER HEALTH INSURANCE

Name of Insured:	Name of Insurance plan/carrier:	List ALL Dependents and/or spouse covered under this Policy:
Original Effective Date: Policy #:	Type of Coverage (Mark all that Apply): Medical ☐ Prescription ☐ Dental ☐ Vision ☐	

DEPENDENT INFORMATION

LIST ALL ELIGIBLE DEPENDENT CHILDREN - ATTACH A SEPARATE SHEET IF NEEDED. **PROVIDE COPIES (FRONT AND BACK) OF ALL OTHER INSURANCE CARDS COVERING DEPENDENTS INCLUDING THEIR EFFECTIVE DATES.**

First/Last Name:	Relationship (Son/Daughter, Stepson/Stepdaughter)	Full SSN	Birth Date	Employed? Yes or No	Does dependent have other Health Insurance?

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 eligible dependents, as defined by the TEWF, I agree to notify the Fund office if there is a change in any dependent's status such change of spouse's employment or eligibility for coverage, divorce, birth, or adoption of a child, etc. I further realize that failure to disclose other insurance coverage information or to provide false or misleading information to the TEWF is considered a fraudulent act against the Fund. A fraudulent act may result in retroactive 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