TOLEDO ELECTRICAL WELFARE FUND

2027 ENROLLMENT FORM

419.666.4450 phone | 419.666.5410 fax | enrollment@electricalfunds.org

PLEASE PRINT AND COMPLETE FORM IN DARK BLUE OR BLACK INK

*****LIST ONLY THE FAMILY MEMBERS YOU WANT TO COVER ON YOUR POLICY*****

New Participant _____ Change/Add ____ Bi-Annual Enrollment__**X**__

PARTICIPANT (LOCAL 8 MEMBER) INFORMATION*			
***If you are a Surviving Spouse, please list your information in this box**			
First/Last Name:	Birthday:	UID or Last 4 of SSN:	
Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Email:	

Circle One:	**Circle One:**	*If Married:*	*If Divorced:*
Male | Female	Single | Married | Widowed	Date of Marriage:	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? Y / N	Does your spouse have ANY other Insurance? * Y / N

DEPENDENT INFORMATION

LIST ALL ELIGIBLE DEPENDENT CHILDREN (ATTACH AN ADDITIONAL SHEET IF NEEDED).						
First/Last Name:	Relationship (Son/Daughter, Stepson/Stepdaughter)	Full SSN	Birth Date	Does dependent have ANY other Insurance? *	Type of coverage:	Is the insurance State Medicaid?
				Y / N	M/D/RX/V	Y / N
				Y / N	M/D/RX/V	Y / N
				Y / N	M/D/RX/V	Y / N
				Y / N	M/D/RX/V	Y / N
				Y / N	M/D/RX/V	Y / N
				Y / N	M/D/RX/V	Y / N

***If you, your spouse, or your dependents have *any* other health insurance, fill out this section completely and provide a copy of the front and back of all insurance card(s)- ATTACH AN ADDITIONAL SHEET IF NEEDED.**

OTHER HEALTH INSURANCE – *ALL FIELDS MUST BE COMPLETED*

Name of Insured: Relationship to Insured:	Name of Insurance plan/carrier: Type of Coverage (Circle all that Apply): Medical | Dental | RX | Vision Other: _____	List ALL Dependents covered under this Policy:
Original Effective Date:		Policy #:

I hereby authorize any physician, hospital, in surer, 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