

**PLUMBERS AND STEAMFITTERS LOCAL UNION NO. 33
HEALTH & WELFARE FUND**

2017 Annual Continued Eligibility Verification Form

This form must be completed by each participant every year and is due by December 31st. All claims submitted after that date will not be processed until this form and any other necessary or requested documentation has been received by the Fund Office.

Participant Name: _____

Participant Social Security Number or Id Number: _____

Participant Address: _____

City: _____

State: _____

Zip Code: _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Emergency Contact Name: _____

Relationship: _____ **Phone:** _____

Marital Status:

Single ___

Married ___

Separated ___

Divorced ___

Widowed ___

Date of Marriage: _____

Date of Separation or Divorce: _____

**PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING
YOUR SPOUSE:**

Spouse's Name: _____

Is your Spouse employed? _____ **Spouse Phone:** _____

Yes ___ No ___

If yes, please complete the enclosed Spouse Declaration form. Also, if your spouse does not have insurance be sure to provide the necessary documentation from his/her employer.

(Continue on back)

PRINT NAMES OF ALL DEPENDENTS AND OTHER REQUESTED INFORMATION

List Dependents	Relationship			Does this child have other coverage? If yes, please indicate if medical, dental, prescription or vision.	Other Insurance Coverage			
	Son	Daughter	Stepchild		Effective date of coverage	Policy holder and relationship to the child	Policy holder date of birth	Insurance Company

Effective January 1, 2011, dependent children are eligible until the age of 26 regardless of marital or student status. If you have a dependent that is age 19 or older you must complete the enclosed **Dependent Declaration of Coverage form**. If they have insurance through their employer or spouse, this Plan is secondary. If disabled, proof of dependent's incapacity and dependency must be submitted at least two (2) months before such dependent's attainment of age 26.

Completion of dependent eligibility is subject to Fund Office Approval. The Fund does require Birth Certificates, Marriage Certificates and/or Divorce Decree's. Birth Certificates are only required for children.

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, pharmacists, hospitals, or other institutions rendering care and treatment to furnish the Plumbers and Steamfitters Health & Welfare Fund with information regarding benefits to which I/We may be entitled. A copy of the authorization shall be considered as effective and valid as the original.

Date _____

Participant Signature _____

Spouse Signature _____

Fund Office use only.

BC on file _____	Follow up date and info requested: _____
Marriage license on file _____	_____
Divorce Decree on file _____	_____
Other _____	_____