Plumbers & Steamfitters Local 33
Health & Welfare Fund Office

NOTIFICATION OF NEW SPOUSE OR CHILD

Participant Name: _____

Participant Address: _____

City: _____ State: _____ Zip Code: _____

Participant 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: _____
Spouse's Social Security Number: _____ Date of Birth: _____

Is your Spouse employed?
Yes___ No ___

If yes, please complete the enclosed Declaration of Spouse Health Coverage form. Also, be sure to include documentation from your spouse's employer if needed.

(Continue on back)

PRINT NAMES OF ALL DEPENDENTS AND OTHER REQUESTED INFORMATION

Dependents		Relationship			Other Insurance Coverage				
lame & Social Security Number	Date of Birth	Son	Daughter	Stepchild	Does this child have other coverage? If yes, please indicate if medical, dental, prescription or vision.	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 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 19.

Completion of dependent eligibility is subject to Fund Office Approval. The Fund does require Birth Certificates, Marriage Certificates and/or Divorce Decree's. Until we have received all of this information ID cards will not be issued. Birth Certificates are only required for children. When adding a newborn to the policy we will require a copy of the Birth Certificate and Social Security Card.

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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 _____