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 ____ Date of Marriage: _____
Separated ____ Date of Separation: _____
Divorced ____ Date of Divorce: _____
Widowed ____

PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING YOUR SPOUSE:

Spouse's Name: _____
Spouse's SSN: _____ Date of Birth: _____

Spouse's Address: _____

Is your Spouse employed?

Yes___ No ___

Does your spouse have Medicare benefits due to disability?

Yes____ No____

If yes, please complete the enclosed Declaration of Spouse Health Coverage form or submit proof of Medicare benefits. Also, be sure to include documentation from your spouse's employer if spouse not enrolled in employer offered Plan.

(Continue on back)

PRINT NAMES OF ALL DEPENDENTS AND OTHER REQUESTED INFORMATION

Dependents		Relationship			Other Insurance Coverage				
Name & 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 26.

Completion of dependent eligibility is subject to Fund Office Approval. The Fund Office requires Birth Certificates, Social Security Cards, Marriage Certificates and/or Divorce Decree's for all participants. ID cards will be issued once all required documentation is received.

****

Under penalties of perjury, I/We jointly declare that the information contained in this document is true and correct to the best of my/our knowledge, information, and belief. I/We understand that the Fund reserves the right to suspend or terminate my/our health coverage if it concludes that I/We have provided false or misleading information on this form. 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 _____