Sheet Metal Workers' Local Union No. 91 Health and Welfare Fund

Fund Office • 8124 42nd Street, West • Rock Island, Illinois • 61201• 1-309-787-0695, extension 18

Benefits Coverage Application Form

To help ensure timely and accurate payment of benefit claims, please take a few minutes to complete this form. Please submit your completed form to the Fund Office in the enclosed, self-addressed envelope.

Section 1: About You

Member Name:	Member Social Securily Number:	
Member Date of Birth:	Member Telephone Number:	
Street Address:		
City:	State:	Zip:

Section 2: About Your Spouse

Spouse's Name:	Spouse's Social Security Number:	
Spouse's Date of Birth:		
Is your spouse employed? ❑ Yes ❑ No	Does your spouse have medical coverage available through his or her employer? (Please check the applicable checkbox) ❑ Yes and spouse is enrolled in this coverage ❑ Yes but spouse is not enrolled in this coverage ❑ No	
Spouse's Employer:	Spouse's Employer's Telephone Number:	
Name of Spouse's Medical Insurance:		
Group or Identification Number:	Effective Date of Coverage:	
Does spouse have single or family coverage? ❑ Single Coverage ❑ Family Coverage	Type of Coverage (Check All That Apply): ❑ Medical ❑ Dental ❑ Vision ❑ Prescription Drug	Monthly Cost of Other Coverage:

Section 3: About Your Dependent Children up to 26 years of Age

If listing children (natural or adopted) and you are divorced or never married to the other parent, you must list any/all other insurance.

Dependent's Name:_____ Date of Birth: _____ Social Security Number: _____	Dependent's Employer's Name: _____ Dependent's Employer's Phone Number: _____ Dependent's Employer or Other Insurance:_____ Insurance Co. Phone No.: _____ Group/ID No.: _____ ❑ Single Coverage ❑ Family Coverage Type of Coverage: ___ Medical ____ Dental ____Vision ____Prescription

(Over)

Dependent's Name:__________________ Date of Birth: __________________ Social Security Number: ________________	Dependent's Employer's Name: __________________ Dependent's Employer's Phone Number: ________________ Dependent's Employer **or** Other Insurance:________________ Insurance Co. Phone No.: __________ Group/ID No.: ________ ☐ Single Coverage ☐ Family Coverage Type of Coverage: ___ Medical ____ Dental ____Vision ____Prescription
Dependent's Name:__________________ Date of Birth: __________________ Social Security Number: ________________	Dependent's Employer's Name: __________________ Dependent's Employer's Phone Number: ________________ Dependent's Employer **or** Other Insurance:________________ Insurance Co. Phone No.: __________ Group/ID No.: ________ ☐ Single Coverage ☐ Family Coverage Type of Coverage: ___ Medical ____ Dental ____Vision ____Prescription
Dependent's Name:__________________ Date of Birth: __________________ Social Security Number: ________________	Dependent's Employer's Name: __________________ Dependent's Employer's Phone Number: ________________ Dependent's Employer **or** Other Insurance:________________ Insurance Co. Phone No.: __________ Group/ID No.: ________ ☐ Single Coverage ☐ Family Coverage Type of Coverage: ___ Medical ____ Dental ____Vision ____Prescription
Dependent's Name:__________________ Date of Birth: __________________ Social Security Number: ________________	Dependent's Employer's Name: __________________ Dependent's Employer's Phone Number: ________________ Dependent's Employer **or** Other Insurance:________________ Insurance Co. Phone No.: __________ Group/ID No.: ________ ☐ Single Coverage ☐ Family Coverage Type of Coverage: ___ Medical ____ Dental ____Vision ____Prescription

Section 4: Your Signature

By signing below, I attest that the above information is accurate to the best of my knowledge.

Member Signature:	Date: