

### **IBEW Local 300** Enrollment/Change Form

New	Enrollment
No C	hange
Char	nge

P

			EMPLO	SEI	UST COMI	EMPLOY	EE PAP	TICIP	ANT INF	ORMAT	ON				
cial Secur	rity Number		Last Name		ck if new				st Name				MI	Date of I	Birth
													State	Zip Code	0
me Mailin	g Address	check if new	N				City						Sidle	Zip Codi	u,
Sender Home Phone				Work Pho	ne					Current	Marital Stat	us			
Male	Female												SING	LE	MARRIED
18 18	2 7- 19		WESSING.		SECTIO	ON 2 - D	EPENDE	NT IN	FORMA			-			Enter "Dep"
	Check		LAST NAME		FI	RST NAM	E	MI	SEX		OF BIRTH D/YYYY	SOCI	AL SECU	RITY #	Relationship Code
ouse or	One Add		LAST NAME			1051 11110									
rtner	Delete							_							
p-1	Add Delete								□F						
p-2	Add Delete														
p-3	Add								Шм						
	Delete														
p-4	Add Delete														
p-5	Add														
	Delete								DF						1
Elect	Medical Cov	erage:			ECTION 3			Elect	Dental C	overage		EE Eami		EE + Sp EE + Ch	ouse
] Elect	Medical Cov	erage:			EE + Spous	e.						🗌 Fami	ly 🛛	EE + Ch	ild
] Waiv	e Coverage:	Medical						Waive	Covera	ge: Dent	ai				
				2010	SECTION	4 - SPO	USE EMP	OYE	R INFO	RMATIO	N				
			o If yes, provid		e? Medical	Employer:		Denta	I: 🗆 Ye:	s 🗌 No					
oes Spo	ouse's Employe	er offer medie dependent(s	cal and/or dent	tal coverage	ge? Medical	Employer: <u>ECTION</u> erage?	□ No 5 - OTH	Denta		s 🗌 No iE If Yes, co		ow and pro	Eff	fective Date	
oes Spo o you, y olicyholde	ouse's Employe rour spouse or er Name	er offer medie dependent(s	cal and/or dent ) maintain othe Policy Number	tal coverage	ge? Medical S r dental cove Group N	Employer: <u>ECTION</u> erage? umber	No 5 - OTH YES Insurance	Denta ER CO N ce Compa	I: Yes VERAG IO any Name 8	s No If Yes, co & Address		ow and pro	Eff	fective Date	2P 🗖 Family
oes Spo o you, y olicyholde	ouse's Employe rour spouse or er Name	er offer medie dependent(s	cal and/or dent	tal coverage	ge? Medical S or dental cove	Employer: <u>ECTION</u> erage? umber	No 5 - OTH YES Insurance	Denta ER CO N ce Compa	II: Yes	s No If Yes, co & Address		ow and pro	Eff Eff	fective Date	2P 🗖 Family
oes Spo o you, y olicyholde	ouse's Employe your spouse or er Name er Name	er offer medie dependent(s	cal and/or dent ) maintain other Policy Number Policy Number	tal coverage er health o	ge? Medical S or dental cove Group N Group N	Employer: <u>Yes</u> ECTION erage? umber umber	No <b>5 - OTH</b> YES Insuranc	Denta ER CO Note Compa See Compa	II: Yes	s No No No No No No No No No No	omplete belo		Eff Eff	fective Date	2P 🔲 Family
oes Spo o you, y olicyhold olicyhold re you, <b>yes, at</b>	ouse's Employe our spouse or er Name er Name your spouse or tach a copy o	er offer medie dependent(s r any dependent	cal and/or dent ) maintain other Policy Number Policy Number dents listed in S card(s).	er health o Section 2 e ctively Wo	ge? Medical S in dental cove Group N Group N enrolled in M rking	Employer: ECTION ECTION erage? umber umber edicare? [ edicare? [	No 5 - OTH YES Insuranc Insuranc Yes Under Ag	Denta ER CO No ce Compa No ge 65	I: Yee VERAG IO any Name & any Name &	s No E If Yes, cc & Address & Address D (End St	omplete belo age Renal [	Disease)	Eff D Eff	fective Date	2P 🗆 Family
oes Spo o you, y olicyhold olicyhold re you, <b>yes, at</b>	ouse's Employe our spouse or er Name er Name your spouse or tach a copy o	er offer medie dependent(s r any dependent	cal and/or dent ) maintain other Policy Number Policy Number dents listed in S card(s).	er health o Section 2 e ctively Wo	ge? Medical S in dental cove Group N Group N enrolled in M rking	Employer: ECTION ECTION erage? umber umber edicare? [ edicare? [	No 5 - OTH YES Insuranc Insuranc Yes Under Ag	Denta ER CO No ce Compa No ge 65	I: Yee VERAG IO any Name & any Name &	s No E If Yes, cc & Address & Address D (End St	omplete belo age Renal [	Disease)	Eff D Eff	fective Date	2P 🗆 Family
oes Spo o you, y olicyhold olicyhold rre you, f yes, at Vill this j	ouse's Employe our spouse or er Name er Name your spouse or tach a copy o plan replace ex	er offer media dependent(s any depend f Medicare of isting health	cal and/or dent ) maintain other Policy Number Policy Number dents listed in S card(s). A insurance cov	tal coverage er health o Section 2 e ctively Wo	ge? Medical S r dental cove Group N Group N enrolled in M rking F S YES N	Employer: Carage? ECTION arage? umber edicare? Ectired ECTION O If yees, a	No 5 - OTH YES Insurance Insurance Yes Under Age 6: HIPA Mittach a ce	Denta ER CO No ce Compa No ge 65 A COM rtificato	II: Ye: VERAG IO any Name & any Name & IPLIANC a of prior	s No No No No No No No No No No	omplete belo age Renal [ surance co	Disease) overage.	Your Price	fective Date Single 2 fective Date Single 2 or insurer v	2P
oes Spo o you, y olicyhold olicyhold are you, f yes, at Will this p	ouse's Employe rour spouse or er Name er Name your spouse or ttach a copy of plan replace ex	er offer media dependent(s any depend f Medicare of isting health	cal and/or dent ) maintain other Policy Number Policy Number dents listed in S card(s).	tal coverage er health o Section 2 e ctively Wo verage? [	ge? Medical S r dental cove Group N Group N Group N anrolled in M rking F S YES N SEC	Employer: CTION arage? umber edicare? Retired ECTION O If yes, a CTION 7:	No 5 - OTH YES Insurance Insurance Insurance Standard Construction SUBSCI	Denta ER CO No ce Compa ce Compa ce 65 A COM rtificato RIBER	II: Yes VERAG IO any Name & any Name & ESR IPLIANC e of prior SIGNAT	s No No No No No No No No No No	age Renal I	Disease)	Your Price	fective Date	2P
oes Spo o you, y olicyhold olicyhold re you, f yes, at Vill this p certify t	ouse's Employe rour spouse or er Name er Name your spouse or tach a copy of plan replace ex hat the stateme	er offer media dependent(s any depend f Medicare of isting health ents on this e	cal and/or dent maintain othe Policy Number Policy Number dents listed in S card(s)A insurance cov	tal coverage er health o Section 2 e ctively Wo rerage? [ n and all in any inform	ge? Medical S or dental cove Group N Group N enrolled in M rking F YES N SEC formation function	Employer: ECTION arage? umber umber edicare? [ tetired _ ECTION O If ves, a CTION 7: mished by ding Protec	No 5 - OTH YES Insurance Insurance Insurance Standard Construction SUBSCI	Denta ER CO No ce Compa ce Compa ce 65 A COM rtificato RIBER	II: Yes VERAG IO any Name & any Name & ESR IPLIANC e of prior SIGNAT	s No No No No No No No No No No	age Renal I surance co t of my know	Disease)	Your Price	fective Date	2P
ooes Spo bo you, y bolicyhold Policyhold Are you, f yes, at Will this p certify t boermit at dba CBA	ouse's Employe rour spouse or er Name er Name your spouse or ttach a copy of plan replace ex	er offer media dependent(s any depend f Medicare of isting health ents on this e provider to re- signated age	cal and/or dent maintain othe Policy Number Policy Number dents listed in S card(s)A insurance cov	tal coverage er health o Section 2 e ctively Wo rerage? [ n and all in any inform	ge? Medical S or dental cove Group N Group N enrolled in M rking F YES N SEC formation function	Employer: ECTION arage? umber umber edicare? [ tetired _ ECTION O If ves, a CTION 7: mished by ding Protec	No 5 - OTH YES Insurance Insurance Insurance Standard Construction SUBSCI	Denta ER CO No ce Compa ce Compa ce 65 A COM rtificato RIBER	II: Yes VERAG IO any Name & any Name & ESR IPLIANC e of prior SIGNAT	s No No No No No No No No No No	age Renal I	Disease)	Your Price	fective Date	2P 🔲 Family
voes Spo vojecyhold volicyhold volicyhold vre you, f yes, at Will this p certify t oermit a dba CBA	ouse's Employe rour spouse or er Name your spouse or tach a copy o plan replace ex hat the statemen ny healthcare p belathcare p	er offer medie dependent(s any depend f Medicare of isting health ents on this e rovider to re signated age re	cal and/or dent ) maintain other Policy Number Policy Number dents listed in S card(s). A insurance cov enrollment form lease/disclose ent for purpose	tal coverage er health o Section 2 e ctively Wo rerage? [ n and all in any inform es of admin	ge? Medical S or dental cove Group N Group N Group N Anrolled in M rking F S YES N SEC formation funation funation (including insterring coversion)	Employer: Control Control Con	No S - OTH YES Insuranc Insuranc Yes Under Ag G: HIPA Insuranc SUBSCI me are tructed Health	Denta ER CO No ce Compa No ge 65 A COM rtificatu RIBER ne and co n Inform	II: Yes VERAG IO any Name 8 IO ESR IPLIANC 9 of prior SIGNAT complete t ation) acc	s No No No No No No No No No No	age Renal I surance co t of my know onnection w Date	Disease) verage. vledge. I vith any pa	Your Price	fective Date Single 2 fective Date ISingle 2 for insurer v enrolled d ure care of	2P
oes Spo o you, y olicyhold olicyhold re you, f <b>yes, at</b> Vill this p certify t sermit at iba CBA Subscri	ouse's Employe our spouse or er Name er Name your spouse or tach a copy of plan replace ex hat the statement hat the statement hat the statement ber's Signatur	any dependent(s any dependent f Medicare of isting health ents on this e rovider to re- isignated age re	cal and/or dent ) maintain other Policy Number Policy Number dents listed in S card(s). A insurance cov enrollment form lease/disclose ent for purpose	tal coverage er health o Section 2 e ctively Wo rerage? [ n and all in any inform es of admin	ge? Medical S or dental cove Group N Group N Group N Anrolled in M rking F S YES N SEC formation funation funation (including insterring coversion)	Employer: Contemployer: ECTION arage? umber edicare? Ectired Ectired ECTION O If yes, a CTION 7: mished by ding Protec erage. OYER C	No 5 - OTH YES Insurance Insu	Denta ER CO No ce Compa No ge 65 A COM rtificatu RIBER ne and co n Inform	II: Yes VERAG IO any Name 8 IO ESR IPLIANC 9 of prior SIGNAT complete t ation) acc	s No No No No No No No No No No	age Renal I surance co t of my know onnection w Date	Disease) verage. vledge. I vith any pa	Your Price	fective Date Single 2 fective Date ISingle 2 for insurer v enrolled d ure care of	2P
oes Spo o you, y olicyhold olicyhold re you, f yes, at Yill this p certify t bermit an ba CBA Subscri	ouse's Employe our spouse or er Name er Name your spouse or tach a copy of plan replace ex hat the statement hat the statement hat the statement ber's Signatur	er offer medie dependent(s any depend f Medicare of isting health ents on this e rovider to re signated age re ****E Medical Effe	cal and/or dent ) maintain other Policy Number Policy Number Policy Number insurance cov enrollment form lease/disclose ent for purpose EMPLOYER I ective Date:	tal coverage er health o Section 2 e ctively Wo rerage? [ n and all in any inform as of admin	ge? Medical S or dental cove Group N Group N Group N enrolled in M rking F S YES N SEC formation fun nation (includ nistering cove	Employer: Contemployer: ECTION arage? umber edicare? Ectired Ectired ECTION O If yes, a CTION 7: mished by ding Protec erage. OYER C	No 5 - OTH YES Insuranc Insuranc Yes Under Ag Control Grade Grade Grade Grade Grade HIPA	Denta ER CO No ce Compa No ce 65 A COM rtificato RIBER re and co n Inform	IL: Ye: VERAG IO any Name 8 any Name 8 ESR IPLIANC a of prior SIGNAT complete t ation) acc MPLETE Reh	s No No No No No No No No No No	age Renal I surance co tof my know connection w Date DPRIATE	Disease) werage. vledge. I ith any pa AREAS	Your Price	fective Date Single 2 fective Date ISingle 2 for insurer v enrolled d ure care of	2P
oes Spo o you, y olicyhold olicyhold re you, f yes, at Yill this p certify t bermit an ba CBA Subscri	ouse's Employe rour spouse or er Name er Name your spouse or ttach a copy of plan replace ex hat the statemen y healthcare p Blue, or its de ber's Signatur	any dependent(s any dependent f Medicare of isting health ents on this e rovider to re- isignated age re	cal and/or dent ) maintain other Policy Number Policy Number Policy Number insurance cov enrollment form lease/disclose ent for purpose EMPLOYER I ective Date:	tal coverage er health o Section 2 e ctively Wo rerage? [ n and all in any inform as of admin	ge? Medical S or dental cove Group N Group N Group N Anrolled in M rking F S YES N SEC formation funation funation (including insterring coversion)	Employer: Contemployer: ECTION arage? umber edicare? Ectired Ectired ECTION O If yes, a CTION 7: mished by ding Protec erage. OYER C	No 5 - OTH YES Insuranc Insuranc Yes Under Ag Control Grade Grade Grade Grade Grade HIPA	Denta ER CO No ce Compa No ce 65 A COM rtificato RIBER re and co n Inform	IL: Ye: VERAG IO any Name 8 any Name 8 ESR IPLIANC a of prior SIGNAT complete t ation) acc MPLETE Reh	s No No No No No No No No No No	age Renal I surance co t of my know onnection w Date	Disease) werage. vledge. I ith any pa AREAS	Your Price	fective Date ISingle 2 fective Date ISingle 2 Single 2 Cor insurer ( enrolled d ure care of V****	2P   Family 2P   Family 2P   Family will give you this form ependants agree to r treatment to CBA, I
oes Spo o you, y olicyhold re you, yes, at vill this p certify t ermit ar ba CBA Subscri COVERJ EFFECT	ouse's Employe rour spouse or er Name your spouse or ttach a copy of plan replace ex hat the statemeny healthcare p A Blue, or its de ber's Signatur	er offer media dependent(s e any depend f Medicare of isting health ents on this e rovider to re signated age re ****E Medical Effe Date of Hire Plan Divisio	cal and/or dent ) maintain other Policy Number Policy Number Policy Number Policy Number insurance cov entoliment form lease/disclose ent for purpose EMPLOYER I ective Date: : : :	tal coverage er health o Section 2 e ctively Wo rerage? [ n and all in any inform as of admin	ge? Medical S or dental cove Group N Group N Group N enrolled in M rking F S YES N SEC formation fun nation (includ nistering cove	Employer: Contemployer: ECTION arage? umber edicare? Ectired Ectired ECTION O If yes, a CTION 7: mished by ding Protec erage. OYER C	No 5 - OTH YES Insuranc Insuranc Yes Under Ag Control Grade Grade Grade Grade Grade HIPA	Denta ER CO No ce Compa No ce 65 A COM rtificato RIBER re and co n Inform	IL: Ye: VERAG IO any Name 8 any Name 8 ESR IPLIANC a of prior SIGNAT complete t ation) acc MPLETE Reh	s No No No No No No No No No No	age Renal [ surance co t of my know onnection w Date DPRIATE	Disease) verage. vledge. I ith any pa AREAS rollment dical:	Your Price and any vast or future BELOW	fective Date Single 2 fective Date fective Date fe	2P   Family 2P   Family 2P   Family will give you this form ependants agree to r treatment to CBA, 1 t Status: e
oes Spo o you, y olicyhold olicyhold re you, yes, at vill this p certify t ermit ar ba CBA Subscri COVERJ EFFECT	ouse's Employe rour spouse or er Name your spouse or ttach a copy of plan replace ex hat the statemeny healthcare p A Blue, or its de ber's Signatur	er offer media dependent(s any depend f Medicare of isting health ents on this e rovider to re signated age e ****E Medical Effe Date of Hire Plan Division/Sut	cal and/or dent ) maintain other Policy Number Policy Number Policy Number insurance cov entollment form lease/disclose ent for purpose EMPLOYER I ective Date:	Exection 2 e crively Wo rerage? [ n and all in any inform as of admin USE ONI	ge? Medical S or dental cove Group N Group N Group N Caroup N Annolled in M rking F S YES N SEC formation fu nation (includ nistering cove A - EMPL bility Date:	Employer: Press ECTION arage? umber edicare? [ edicare? [ edicare? [ edicare? [ edicare? [ edicare? [ edicare? [ edicare? ] ECTION O If yes, a TION 7: mished by ding Protect erage. OYER C Dental Eff	No 5 - OTH YES Insuranc Insuranc Yes Under Ag Control Grade Grade Grade Grade Grade HIPA	Denta ER CO No ce Compa Se Com	IL: Ye: VERAG IO any Name 8 any Name 8 ESR IPLIANC a of prior SIGNAT complete t ation) acc MPLETE Reh	s No No No No No No No No No No	age Renal [ surance co t of my know onnection w Date DPRIATE	Disease) verage. vledge. I ith any pa AREAS rollment dical:	Your Price and any vast or future BELOW	fective Date Single 2 fective Date JSingle 2 fective Date JSingle 2 fective Date fective Date	2P   Family 2P   Family 2P   Family will give you this form ependants agree to r treatment to CBA, 1 1 1 1 1 1 1 1 1 1 1 1 1
oes Spo o you, y olicyhold olicyhold re you, f yes, at Vill this p certify t sermit at ba CBA Subscri COVERJ EFFECT	ouse's Employe rour spouse or er Name your spouse or ttach a copy of plan replace ex hat the statemeny healthcare p A Blue, or its de ber's Signatur	er offer media dependent(s any depend f Medicare of f Medicare of issignated age ****E Medical Effe Date of Hire Plan Division/Sut Division/Sut Division/Sut	cal and/or dent ) maintain other Policy Number Policy Number Policy Number dents listed in S card(s). A insurance cov enrollment form lease/disclose ent for purpose EMPLOYER I ective Date: : : : : : : : : : : : : :	tal coverage er health o Section 2 e ctively Wo rerage? [ n and all in any inform any inform ess of admir USE ONI or Eligi	ge? Medical S r dental cove Group N Group N enrolled in M rking F S YES N SEC formation fu mation (inclue nistering cove LY - EMPL bility Date:	Employer: Press ECTION arage? umber edicare? [ tetired ] ECTION o If yes, a TION 7: mished by ding Protece erage. OYER C Dental Eff	No  S - OTH  YES  Insuranc  Insuranc  Yes Under Ag  C HIPA  ttach a ce  SUBSCI me are tru cted Health  HECK AN fective Date:  New HIPA  BRA Division	Denta ER CO No ce Compa ce Compa ce 65 A COM rtificata RIBER re and co Inform ND CO	IL: Ye: VERAG IO any Name 8 any Name 8 ESR IPLIANC a of prior SIGNAT SIGNAT SIGNAT MPLETE Ation) acc MPLETE	s No No No No No No No No No No	age Renal [ surance co t of my know onnection w Date DPRIATE	Disease) verage. vledge. I ith any pa AREAS rollment dical: an	Your Price and any vast or future BELOW	fective Date Single 2 fective Date fective Date fe	2P   Family 2P   Family 2P   Family will give you this form ependants agree to r treatment to CBA, 1 t Status: ie
oes Spo o you, y olicyhold olicyhold re you, yes, at vill this p certify t ermit ar ba CBA Subscri COVERJ EFFECT	ouse's Employe rour spouse or er Name your spouse or ttach a copy of plan replace ex hat the statemeny healthcare p A Blue, or its de ber's Signatur	er offer media dependent(s any depend f Medicare of f Medicare of issignated age ****E Medical Effe Date of Hire Plan Division/Sut Division/Sut Division/Sut	cal and/or dent ) maintain other Policy Number Policy Number Policy Number insurance cov entollment form lease/disclose ent for purpose EMPLOYER I ective Date:	tal coverage er health o Section 2 e ctively Wo rerage? [ n and all in any inform any inform ess of admir USE ONI or Eligi	ge? Medical S r dental cove Group N Group N enrolled in M rking F S YES N SEC formation fu mation (inclue nistering cove LY - EMPL bility Date:	Employer: Press ECTION arage? umber edicare? [ tetired ] ECTION o If yes, a TION 7: mished by ding Protece erage. OYER C Dental Eff	No  S - OTH  YES  Insuranc  Insuranc  Yes Under Ag  C HIPA  ttach a ce  SUBSCI me are tru cted Health  HECK AN fective Date:  New HIPA  BRA Division	Denta ER CO No ce Compa ce Compa ce 65 A COM rtificata RIBER re and co Inform ND CO	IL: Ye: VERAG IO any Name 8 any Name 8 ESR IPLIANC a of prior SIGNAT SIGNAT SIGNAT MPLETE Ation) acc MPLETE	s No No No No No No No No No No	age Renal [ surance co t of my know onnection w Date DPRIATE DOPRIATE Date DPRIATE Plan Type De Dental Plan	Disease) verage. vledge. I : ith any per- AREAS collment dical: an ntal: n	Your Price	fective Date Single 2 fective Date fective Date Single 2 fective Date fective Da	2P   Family 2P   Family 2P   Family will give you this form ependants agree to r treatment to CBA, nt Status: ie ie
voes Spo olicyhold olicyhold re you, f yes, at vill this p certify t bermit an dba CBA Subscri COVERA EFFECT EMPLO STATUS	ouse's Employe rour spouse or er Name er Name your spouse or tach a copy of plan replace ex hat the statemen hy healthcare p Blue, or its de ber's Signatur AGE IVE DATES: YEE S:	er offer media dependent(s any depend f Medicare of f Medicare of issignated age ****E Medical Effe Date of Hire Plan Division/Sut Division/Sut Division/Sut	cal and/or dent ) maintain other Policy Number Policy Number Policy Number dents listed in S card(s). A insurance cov enrollment form lease/disclose ent for purpose CMPLOYER I ective Date: Con/Subgroup: ivision #: cate your division	tal coverage er health o Section 2 e ctively Wo rerage? [ n and all in any inform any inform ess of admir USE ONI or Eligi	ar dental cove Group N Group N Group N Group N Group N Second Se	Employer: ECTION arage? umber edicare? Ectired Ectired ECTION O If yes.a ECTION O If yes.a ECTION O If yes.a ECTION O If yes.a ECTION Coverage. Dental Eff COVER C Coverage	No 5 - OTH YES Insuranc Insur	Denta ER CO No ce Compa No ce 65 A COM rtificato RIBER re and co n Inform ND CO Hire A Qualifi ng the ir credita	IL: Ye: VERAG IO any Name 8 BESR IPLIANC e of prior SIGNAT complete t ation) acc MPLETE PLETE MPLETE Addree ble Cover	s No No No No No No No No No No	age Renal I surance co t of my know connection w Date DPRIATE Open Em be event): Plan Type Me Dental Pla Plan Type De Dental Pla e CO	Disease) verage. vledge. I i ith any pa AREAS rollment dical: an ntal:	Your Price	fective Date Single 2 fective Date fective Date Single 2 fective Date fective Da	2P   Family 2P   Family 2P   Family will give you this form ependants agree to r treatment to CBA, 1 1 1 1 1 1 1 1 1 1 1 1 1
Policyhold Policyhold Are you, f yes, at Will this permit an dba CBA Subscri COVERA EFFECT EMPLO STATUS	AGE TVE DATES: YEE S: N FOR S CHANGE:	er offer media dependent(s any depend f Medicare of isting health ents on this e rovider to re- signated age ****E Medical Effe Date of Hire- Division/Sut Date of Hire- Division/Sut Date of a constant Division/Sut Active D You can loc	cal and/or dent cal and/or dent policy Mumber Policy Number Policy Number dents listed in S card(s). A insurance cov enrollment form lease/disclose ent for purpose EMPLOYER I ective Date: con/Subgroup: ivision #: cate your division ate:	tal coverage er health o Section 2 e ctively Wo rerage? [ n and all in any inform any inform ess of admir USE ONI or Eligi	ge? Medical S r dental cove Group N Group N Group N enrolled in M rking F S YES N SEC formation fun nation (includ nistering cove Division # CBAs structure	Employer: ECTION arage? umber edicare? Ectired Ectired ECTION O If yes.a ECTION O If yes.a ECTION O If yes.a ECTION O If yes.a ECTION Coverage. Dental Eff COVER C Coverage	No 5 - OTH YES Insuranc Insur	Denta ER CO No ce Composi- ce Composi- ce Composi- ce 65 A COM rtificator RIBER re and co n Inform ND CO Hire A Qualifi a fing the in ge Credita cribe ev	IL: Ye: VERAG IO any Name 8 BESR IPLIANC e of prior SIGNAT complete t ation) acc MPLETE PLETE MPLETE Addree ble Cover	s No No No No No No No No No No	age Renal I surance co t of my know connection w Date DPRIATE Open Em be event): Plan Type Me Dental Pla Plan Type De Dental Pla e CO	Disease) verage. vledge. I i ith any pa AREAS follment dical: an ntal: n pen Enro	Your Price	tective Date Single   fective Date fective Date Single   fective Date	2P   Family 2P   Family 2P   Family will give you this form ependants agree to r treatment to CBA, nt Status: ie ie



### ENROLLMENT AND **BENEFICIARY FORM** PLEASE PRINT

**INSTRUCTIONS:** This form is to be utilized for enrollment and beneficiary purposes only. All correspondence and questions should be addressed to the Fund/Employer maintaining your eligibility information.

For all new additions and reinstatements, complete the entire form, and sign at the bottom. >

For all other needs, complete the appropriate section, and sign at the bottom. >

Please check:	⊠ New enrollment	□ Reinstatement	□ Address	Change	Beneficiar	y Change	
Name of group policyh	wholder Information nolder:IBEW Local 3				umber: <u># G-3</u> ill ID:		
SECTION B – Insur Life amount: \$50,0 Billing classes:	AD&D amount:	\$_50,000.00	AH amount: \$		_LTD amount: \$		
Duplicate certificate r	equest						
SECTION C – Insur Name of insured:	red Information	First		Middle		☐ Male ☐ Active	<ul> <li>Female</li> <li>Retiree</li> </ul>
Address:							
City:				State:	Zip:		
SSN:				Date of birth:			
				Date started w	orking:		

#### SECTION D - Beneficiary

NOTE: If the beneficiary is being changed, the new beneficiary will replace all prior designations and will be effective as of the date this form is signed.

Beneficiary name	Relationship to Insured	Date of birth	% of share	SSN:
Primary:			%	
1.			%	
2.				
Contingent:			%	
1.				
2.			%	
			I	Date:
WITNESS SIGNATURE (Required for new adds, reinstatements or beneficiary change):			1	Date:
LHFM-ULL-1137a rev 04/16	LEASE READ AND COMPLETE	ALL PAGES		



### ENROLLMENT AND BENEFICIARY FORM PLEASE PRINT

#### FRAUD NOTICE

**<u>California</u>**: For your protection California Law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

<u>New Jersey</u>: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits

Date:

I attest that I have reviewed, understand and acknowledge the fraud warning(s).

Member or Claimant's signature:

PLEASE READ AND COMPLETE ALL PAGES Page 2 of 2 Vermont Department of Taxes PO Box 547 Montpelier, VT 05601-0547

Phone: (802) 828-2551

VT	Form
Η	C-2

# DECLARATION OF HEALTH CARE COVERAGE

This form must be completed annually by all uncovered employees. Employers must retain this form for 3 years.

**Employer:** This form is <u>only</u> to be completed by employees if you offer to pay a portion of a health care plan that provides hospital and physicians services to at least some of your employees. You must retain all employee declaration forms together in a file for three years and be able to produce them in the event of an audit.

Employer's Legal Name (Please print)

IBEW Local 300 Health and Welfare

Employee: Complete and sign this form and return it to your employer. The purpose of this form is to obtain information regarding your health care coverage. The information you provide on this form will be used solely for purposes of determining if your employer must pay Health Care Contributions as required under Vermont law at 32 V.S.A § 10503.

Employee's Full Name (Please print)				
Employee ID or Social Security Number	Date of I	Birth		
Will the employee be under the age of 18 for the entire calendar	year?	<b>YES</b>	NO	

If **YES**, stop. Please sign the bottom of the form and submit it to your employer.

If NO, please continue to complete this form and submit it to your employer.

### Check the box beside the statement that best describes your health care coverage.

### 1. My employer offers health care coverage to me.

I have accepted the health care coverage offered and provided by my employer.

## 2. My employer offers health care coverage to me, and I have <u>not</u> accepted my employer's coverage.

Ĺ	I have health care coverage that includes hospital and physicians services from a source other than Medicaid or Vermont Health Benefit	
	Exchange.	

My coverage is provided through: \_

I am a full-time employee and have health care coverage as an individual through the Vermont Health Benefit Exchange.

I have Medicaid.

I have no health care coverage.

### 3. My employer does not offer health care coverage to me.

- I am a part-time employee who works fewer than 30 hours per week, <u>and</u> I have coverage from a source other than Medicaid that offers hospital and physicians services.
- I am a seasonal employee who expects to work for this employer 20 or fewer weeks during this calendar year, and I have coverage from a source other than Medicaid that offers hospital and physicians services.

I have health care coverage that offers hospital and physicians services.

My coverage is provided through:

I am a part-time or seasonal employee, and I do not have health care coverage or I am covered by Medicaid.

I have no health care coverage.

I certify the above information is accurate and to	rue to best of my knowledge and belief.
Employee Signature	Date
Note: If your health care coverage changes within the year, you mu	st complete a new Declaration of Health Care Coverage.



International Brotherhood of Electrical Workers – Local 300 Health & Welfare Fund AFL – CIO – CLC 3 Gregory Drive South Burlington, VT 05403 Telephone (802) 864-5864 Fax (802) 864-5495 www.ibewlocal300.org

### Short Term Disability Enrollment Form

Requested Effective Date: \_\_\_\_\_

This form needs to be completed and signed in order to be eligible for the Short Term Disability Benefit.

Section 1 - Employee Information:

Name:	

Address: \_\_\_\_\_

Health Coverage (check 1): 
Employee Only
Employee/Child(ren)
Family

□ Employee/Spouse

Section 4 – Subscriber Signature

By signing below, I understand that only I, the member, am eligible for Short Term Disability Benefits through The Plan.

Signature

Date



International Brotherhood of Electrical Workers – Local 300 Health & Welfare Fund AFL – CIO – CLC 3 Gregory Drive South Burlington, VT 05403 Telephone (802) 864-5864 Fax (802) 864-5495 www.ibewlocal300.org

### HSA/HRA Enrollment/Change Form

	Requested Ef	fective Date:
Section 1 - Employee Information:		
Name:		_
Address:		-
E-mail Address:		
Phone:		
Health Coverage (check 1):  Employee Only Employee/Child(ren)  Family	Employee/Spouse	

Section 2 - New Enrollment (check one then go to section 4): Please note that you are required to enroll in an HSA unless you or your dependents are not eligible for this type of account. Please contact the Fund Office if one of the following situations applies to you:

- Employee is eligible for Medicare
- Employee is on another group Medical Plan
- Employee has an under age 26 dependent who is not a tax dependent

□ Health Savings Account (HSA) -or- □ Health Reimbursement Account (HRA)

Section 3 – Change (check one): If you are currently enrolled in our Plan and your circumstances have changed, please select the account you would like to switch to (only at open enrollment January 1)

⊠ Health Savings Account (HSA) -or- □ Health Reimbursement Account (HRA)

Section 4 – Subscriber Signature

Signature

Date