I.B.E.W. LOCAL UNION NO. 126 HEALTH & WELFARE FUND

BENEFITS ENROLLMENT FORM

MEMBER INFORMATION

Name: (Last, First, Middle Initial)		Social Security Number:		
Street Address:		City:	State:	Zip:
Date of Birth:	Date of Hire:	Marital Status:	Gender:	
Home Phone Number:	Cell Phone Number:	Email Address:		

DEPENDENT AND SPOUSE INFORMATION

(Marriage certificate required for spouse. Birth certificate required for each dependent.)

Name: (Last, First, Middle Initial) Other than self-employed is Spouse employed? Yes ☐ or No ☐	Spouse Gender:	Date of Birth:	Social Security Number:
Name: (Last, First, Middle Initial) Dependent employed? Yes ☐ or No ☐	Child Gender:	Date of Birth:	Social Security Number:
Name: (Last, First, Middle Initial) Dependent employed? Yes ☐ or No ☐	Child Gender:	Date of Birth:	Social Security Number:
Name: (Last, First, Middle Initial) Dependent employed? Yes ☐ or No ☐	Child Gender:	Date of Birth:	Social Security Number:
Name: (Last, First, Middle Initial) Dependent employed? Yes ☐ or No ☐	Child Gender:	Date of Birth:	Social Security Number:
Name: (Last, First, Middle Initial) Dependent employed? Yes ☐ or No ☐	Child Gender:	Date of Birth:	Social Security Number:

REVERSE SIDE MUST BE COMPLETED

LIFE BENEFICIARY INFORMATION				
PRIMARY BENEFICIARY				
Name: (Last, First, Middle Initial)	Spouse ☐ Child ☐ Gender:	Date of Birth:	Social Security Number:	%:
Name: (Last, First, Middle Initial)	Spouse ☐ Child ☐ Gender:	Date of Birth:	Social Security Number:	%:
CONTINGENT BENEFICIARY				
Name: (Last, First, Middle Initial)	Spouse ☐ Child ☐ Gender:	Date of Birth:	Social Security Number:	%:
Name: (Last, First, Middle Initial)	Spouse ☐ Child ☐ Gender:	Date of Birth:	Social Security Number:	%:

AUTHORIZATION AND SIGNATURE (sign and date).

- **Release of Information**: I understand that certain information collected by I.B.E.W. Local Union No. 126 Health & Welfare Fund, including some collected using this form, must be sent to Lacher & Associates (consultant to I.B.E.W. Local Union No. 126 Health & Welfare Fund) and to the insurance carriers of the plans in which I have enrolled. I.B.E.W. Local Union No. 126 Health & Welfare Fund, Lacher & Associates and the insurance carriers will treat this information as confidential.

- If the Plan discovers that you have provided false information in your enrollment form or under the Plan's "Working Spouse Rule", then in accordance with the Plan's "Erroneous Payment Rule", you will be required to repay to the Plan: (a) all payments and the value of all benefits paid on behalf of your spouse under the Plan which would not have otherwise been paid had you complied with the "Working Spouse Rule", (b) appropriate interest, (c) any and all costs of collection (including attorney's fees), and (d) penalties directed by the Trustees. In reasonable action to recoup such amounts, including, without limitation, deducting from, or offsetting against, any future benefits and/or payments under the Plan.

Member Signature: **Date:**

I.B.E.W. Local Union No. 126
3455 Germantown Pike
Collegeville, PA 19426
Fax - (610) 489-6988
Email – lu126ibew@comcast.net

Please see the chart below for the individuals who are eligible to be covered under the I.B.E.W. Local Union No. 126 Health & Welfare Fund, as well as the documentation needed for each dependent.

DEPENDENT TYPE	DOCUMENTATION NEEDED
Spouse	Marriage Certificate
Child	Birth Certificate
Step Child	Birth Certificate and Federal Income Tax 1040 Form Showing Claimed as Dependent
Adopted Child	Birth Certificate or Court Order
Court-Ordered Dependent	Court Order

SAMPLE BIRTH CERTIFICATE

SAMPLE MARRIAGE CERTIFICATE

FEDERAL INCOME TAX 1040 FORM

Documents can be emailed, faxed or mailed.

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