PARTICIPANT'S DATA/CLAIM STATEMENT – 2009

(Statement to be completed each year covering all family members and is for medical, dental & vision.)

NECA-IBEW WELFARE TRUST FUND

2120 Hubbard Avenue, Decatur, IL 62526-2871 • Phone: 217-875-0254

FUND PARTICIPANT'S INFORMATION

Participant's Name: ____

Participant's Social Security Number: ______________________ Local Union # __________

Participant's Home Address: ____
Street Apt. #

____
City State Zip Code

Participant's Home Telephone Number: ____

Participant's Date of Birth: ____
Month Day Year

Participant's Sex: __________ Male __________ Female

Participant's Marital Status: __________ Married __________ Single __________ Legally Separated

__________ Widowed __________ Divorced

PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING YOUR SPOUSE:

SPOUSE'S NAME: ____

SPOUSE'S SOCIAL SECURITY NUMBER: ____

SPOUSE'S DATE OF BIRTH: ____

IF YOUR SPOUSE IS EMPLOYED (FULL OR PART TIME), PLEASE PROVIDE THE COMPLETE NAME, ADDRESS AND PHONE NUMBER OF HIS/HER EMPLOYER:

____

If your Spouse changes employment and/or has a change regarding his/her insurance status, contact the Fund Office as soon as possible.

DEPENDENT'S INFORMATION

Complete the following information on **all** children less than 25 years of age and still full time students, you are claiming as eligible dependents. (New laws require the health fund to obtain social security numbers on all dependents).

Name	Date of Birth	Male or Female	Social Security Number

OTHER INSURANCE/COVERAGE (Must be completed if spouse is employed)

Do You, Your Spouse, or Children Have Any Other Available Coverage of the Types Described Below?

A. Group Insurance, or any other arrangement of coverage for individuals in a group? ______ Yes ______ No

B. Private Medical/Dental/Vision Insurance? ______ Yes ______ No

C. Any coverage for Dependents/Students? ______ Yes ______ No

D. Any Federal, State or Other Government Program? ______ Yes ______ No

E. Does your Spouse's Employer offer Health Insurance to Employees? ______ Yes ______ No

If Yes, when is your spouse eligible to enroll for Health Coverage under Employer's Plan?______________________________

If you answered Yes to any of the above questions (A-E), please complete the following:

Insured's Name:____

Insurance Company or Organization Providing Benefits or Services (medical, dental, vision).

____

Name Address Phone #

Policy Number/Identification Number ______________________________ Group # ______________________________

I hereby certify that all of the information provided on this form is true and correct. I hereby authorize my employer ______________________________, to release information regarding my employer's health insurance plan (including the Summary Plan Description) and my eligibility for coverage under the Plan to the NECA-IBEW Welfare Trust Fund. I understand this authorization shall remain in effect as long as I am eligible for benefits under the ______________________ Plan. I understand that the purpose and scope of this authorization is to allow the NECA-IBEW Welfare Trust Fund to verify with my employer whether I am eligible to collect or obtain coverage under my employer's health plan.

SPOUSE'S SIGNATURE (Spouse must sign if employed) ______________________________ DATE ______________

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and believe true, correct and complete. I agree to promptly notify the Fund Trustees in writing in the event of: 1) a change in marital status due to marriage, divorce, or legal separation; 2) the death or disability of a person named here; 3) the birth or adoption of a dependent child; 4) a child's dependent status changes due to age, student status, marriage or financial independence.

EMPLOYEE'S SIGNATURE (Must be signed) ______________________________ DATE ______________

I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning any disability. I will reimburse the Fund for any overpayment made to me or in my behalf due to error on this form.

EMPLOYEE'S SIGNATURE (Must be signed) ______________________________ DATE ______________

claim cannot be processed without your signature