

**NECA-IBEW WELFARE TRUST FUND
 INFORMATION ON CATEGORIES OF BENEFITS**

1. The date of the original certificate: _____
2. Name of group health plan providing the coverage: NECA-IBEW Welfare Trust Fund
3. Name of Participant: _____
4. Social Security Number of Participant: _____
5. Name of individual(s) to whom this information applies: _____

6. The following information applies to the coverage in the certificate that was provided to the individual(s) identified above:
 - a. MENTAL HEALTH: _____ SAME
 - b. SUBSTANCE ABUSE TREATMENT: _____ SAME
 - c. PRESCRIPTION DRUGS: _____ SAME
 - d. DENTAL CARE: _____ SAME
 - e. VISION CARE: _____ SAME

For each category above, enter "N/A" if the individual had no coverage within the category and enter either:

- ◆ both the date that the individual's coverage within the category began and the date that the individual's coverage within the category ended (or indicate if continuing), or
- ◆ "same" on the line if the beginning and ending dates for coverage within the category are the same as the beginning and ending dates for the coverage in the certificate.