



NECA-IBEW WELFARE TRUST FUND



SPOUSAL EMPLOYER / INSURANCE FORM

Date _____
YOUR EMPLOYEE _____
 Social Security # _____
OUR Member _____
 Social Security/ID # _____

Please have the employer complete the following information and return back to the Fund office.

Employer: _____ Address _____ Phone _____

Does the employer offer any health insurance regardless of the number of hours the employee works? YES ___ NO ___ Did they enroll? _____

Hire Date _____ Full Time _____ Part Time _____ PRN _____

Offered only if a FULL TIME employee? YES ___ NO ___ or offered only at hire? YES ___ NO ___ or enroll at enrollment period? YES ___ NO ___

When is the next opportunity to enroll in a **comprehensive health benefit plan**? _____

*IS THE POLICY: **MAJOR MEDICAL** _____; **PRIVATE** _____; **H.S.A.** _____; **H.R.A.** _____

Does the policy follow the birthday rule? YES ___ NO ___ Is the policy for: **family** YES ___ NO ___ or **single** coverage? YES ___ NO ___

DEPENDENTS COVERED: _____

What is the **original effective** date for: _____

HMO _____ **PPO** _____

MEDICAL INSURANCE EFF _____ RX _____ TERMINATION DATE _____
 Name of carrier _____ Address _____
 ID# _____ Group #: _____ Phone # _____

VISION INSURANCE EFF _____ TERMINATION DATE _____
 Name of carrier _____ Address _____
 ID# _____ Group #: _____ Phone # _____

DENTAL INSURANCE EFF _____ TERMINATION DATE _____
 ORTHODONTIA COVERAGE EFF _____ TERMINATION DATE _____
 Name of carrier _____ Address _____
 ID# _____ Group #: _____ Phone # _____

COMMENTS: _____

Please sign and return this form to our office at your earliest convenience.

Signature of HR/Benefits or Employer _____ Phone Number _____ Date completed _____
 Title of person completing form _____

ITEMS MAY BE FAXED OR EMAILED BACK TO:
 217.875.2581 jheberling@neca-ibew.org

THANK YOU

REVISED 6-23-09