PARTICIPANT'S DATA/CLAIM STATEMENT – "DATA CARD"

(Statement to be completed each year covering all family members, as applicable, for medical, prescription drug, dental, and vision benefits.)

NECA-IBEW WELFARE TRUST FUND

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

PARTICIPANT INFORMATION

Participant's Name: _____

Participant's Social Security Number or Alt ID #: _____

Participant's Email Address: _____

Participant's Home Address: _____
Street Apt. #

_____
City State Zip Code

Participant's Telephone Number: _____

Participant's Date of Birth: _____ Local Union (if applicable) _____
Month/Day/Year

Participant's Sex: ○ Male ○ Female ○ Other

MARITAL STATUS

Participant's Marital Status: ○ Married ○ Single ○ Legally Separated ○ Widowed ○ Divorced

Date of Marriage: ____/____/____

Date of Spouse's Death: ____/____/____

Date of Separation: ____/____/____

Date of Divorce: ____/____/____ County and State of Divorce: _____/ _____

SPOUSE INFORMATION

Spouse's Name: _____

Spouse's Social Security Number: _____

Spouse's Date of Birth: _____
Month Day Year

Spouse's Sex: ○ Male ○ Female ○ Other

SPOUSE EMPLOYMENT STATUS

IF YOU ARE MARRIED, YOU MUST COMPLETE THIS SECTION AND YOUR SPOUSE MUST ALSO COMPLETE THE ATTACHED *DATA/CLAIM STATEMENT-SPOUSAL VERIFICATION*.

I certify that my Spouse is (check appropriate one):

_____Employed*

_____Not employed

_____Self-employed*

***Please Note: If your Spouse is employed, including self-employment, and offered any health care coverage through his/her employer plan, your Spouse MUST TAKE THAT COVERAGE REGARDLESS OF HOW MUCH IT MAY COST, or he/she will not be covered for medical and prescription drug benefits under the NECA-IBEW Welfare Trust Fund.**

If your spouse has a change in his or her employment status and/or has a change regarding his or her health care coverage status, you must contact the Fund Office as soon as possible.

DEPENDENT INFORMATION

Complete the following information on all children less than 26 years of age you are claiming as eligible Dependents.

	Name	Date of Birth	Gender	Social Security #	Other Insurance
1.					Yes___No___
2.					Yes___No___
3.					Yes___No___
4.					Yes___No___
5.					Yes___No___
6.					Yes___No___

OTHER INSURANCE/COVERAGE

Do You, Your Spouse, or Children Have Any Other Available Coverage of the Types Described Below? (please add additional pages, if necessary)

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. If your spouse has other coverage; does it include coverage for dependents? Yes____No _____
D. Any Federal, State or Other Government Program? Yes____No_____

If you answered "Yes" to any of the above questions (A-D), please complete the following: (please add additional pages, if necessary, showing the information required below for each additional coverage plan you, your spouse, or children may have):

Insured's Name: _____

Insurance Company or Organization that is providing coverage (medical/drug, dental, vision)

_____

Name Address Phone Number

Policy Number/Identification Number:_____Group # _____

VERIFICATION OF TRUE STATEMENTS

I hereby authorize any physician or any hospital to furnish and disclose all known facts concerningany disability. I hereby certify that the foregoing statements and information contained in this formare true, accurate and complete to the best of my knowledge. I certify that: 1) If I am married, my spouse is required to complete the *Data/Claim Statement-Spousal Verification* form; 2) I am responsible for ensuring the accuracy of the information provided in the Spousal Verification; and 3) I am liable for any misstatements contained therein. I will reimburse the Fund for any overpayment made to me or on my behalf due to error on this form or the *Data/Claim Statement-Spousal Verification* completed by my spouse. I agree to promptly notify the Fund 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 on this form; 3) the birth or adoption of a dependent child; 4) an addition or change in other insurance for any dependent children; or 5) a change in the employment status of my Spouse.

PARTICIPANT'S SIGNATURE (must be signed)_____

claims cannot be processed without your signature

DATE_____

IMPORTANT NOTE: If you are married, *your spouse* will need to complete and sign the *Data/Claim Statement-Spousal Verification* section of this Data Card. As you complete the Participant portion, you will be asked to provide your spouse's email address. Your spouse will then receive an email invitation to electronically complete and sign his/her portion.

NECA-IBEW WELFARE TRUST FUND

DATA/CLAIM STATEMENT - SPOUSAL VERIFICATION

IMPORTANT NOTICE: SPOUSES MUST TAKE EMPLOYER-OFFERED HEALTH CARE COVERAGE REGARDLESS OF COST

I,_____, am the Spouse of the above-named Participant.

I certify that:

- ☐ I am not presently employed.
- ☐ I am presently self-employed and not offered any health care coverage through the self-employed arrangement.*
- ☐ I am presently employed but am not eligible to receive health care coverage through my Employer or my Employer does not provide health insurance benefits to its employees.*
- ☐ I am presently employed and am eligible to receive health insurance benefits through my Employer, but I am not currently enrolled in my Employer's health insurance Plan.* ***If you checked this box, when are you next eligible for enrollment under the Employer's Plan***?

  Insert Date: _____
- ☐ I am presently employed, and I am enrolled in my Employer's health insurance Plan.* ***If you checked this box, please complete the following***:

  Insured's Name:_____

  Insurance Company or Organization that is providing benefits or services (medical, dental, vision):

  _____
  Name Address Phone Number

  Policy Number/Identification Number:_____Group #_____

If you are employed, please provide the following information:

Employer Name:_____Phone Number: (_____)_____

Employer's Address:_____

City:_____State:_____Zip Code:_____

Hire Date:_____Current Position:_____

***Please note:** If you checked an applicable box above and your employer and/or insurance differs from your last reported employer and/or insurance, then you will be sent a "Spousal & Dependent Insurance Form" which should be completed by your employer and returned to the Fund Office.*

I hereby certify that the foregoing statements and information contained in this form are true, accurate and complete to the best of my knowledge. I agree to **IMMEDIATELY** notify the Fund, in writing, in the event of a change in my employment status. **I further acknowledge that if my Employer offers health care coverage then I must take that coverage regardless of how much it may cost and if I fail to do so then I am responsible for all liability incurred by NECA-IBEW Welfare Trust Fund, including claims paid on my behalf.**

FAILURE TO NOTIFY THE FUND OF EMPLOYMENT-BASED COVERAGE OR COMPLETING THIS FORM WITHOUT DISCLOSING ALL MATERIAL FACTS MAY RESULT IN LEGAL ACTION BEING TAKEN AGAINST YOU FOR FRAUD.

SPOUSE'S SIGNATURE (must be signed)_____

DATE_____

AUTHORIZATION TO RELEASE INFORMATION TO
NECA-IBEW WELFARE TRUST FUND

I (spouse) hereby authorize my Employer,_____, to release information (including the Summary Plan Description) regarding my Employer's health insurance plan offerings and myeligibility for coverage under that plan to the NECA-IBEW Welfare Trust Fund ("Fund"). I understand this authorizationshall remain in effect as long as I am employed by my Employer and/or eligible for benefits under my Employer's Plan. I understand thatthe purpose and scope of this authorization is to allow the Fund to verify with my Employer whether I am eligible to collect or obtain coverage under my Employer's health care coverage plan. I further acknowledge that claims will not be paid on my behalf until my Employer returns the "Spousal & Dependent Insurance Form" to the Fund Office.

SPOUSE'S SIGNATURE (must be signed)_____

DATE_____