

ENROLLMENT FORM

N.E.C.A. Local 313 I.B.E.W. Health & Welfare Fund

Last: First: Middle: Suffix:

Address 1:

Address 2:

City: State: Zip Code:

Name of Home Local Union: Local Union #:

Home Phone: Alternate Number:

Social Security Number: - -

Date of Birth: - - Sex: Male Female

Marital Status: (Check One) Married Single Divorced Legally Separated Widowed

E-Mail Address:

OTHER COVERAGE

Do you or any of your dependents have additional health coverage? YES NO

If "YES", what type of coverage? Individual Group

Name of the Insured:

Name of Insurance Carrier:

Telephone Number for Verification of Benefits:

Policy Number: Group Number:

DEPENDENT ENROLLMENT

Last: First: Middle: Suffix:

Social Security Number: - -

Date of Birth: - - Sex: Male Female

Relationship to Participant: (Select One) Spouse (submit copy of marriage certificate) Biological Child (submit copy of birth certificate) Step-child (submit copy of birth certificate)

Other: (Please explain) _____

Marital Status: (Check One) Married Single

Does this dependent reside outside your household? YES NO

If yes, please indicate the address: _____

Last: First: Middle: Suffix:

Social Security Number: - -

Date of Birth: - - Sex: Male Female

Relationship to Participant: (Select One) Spouse (submit copy of marriage certificate) Biological Child (submit copy of birth certificate) Step-child (submit copy of birth certificate)

Other: (Please explain) _____

Marital Status: (Check One) Married Single

Does this dependent reside outside your household? YES NO

Last: First: Middle: Suffix:

Social Security Number: - -

Date of Birth: - - Sex: Male Female

Relationship to Participant: Spouse (submit copy of marriage certificate) Biological Child (submit copy of birth certificate) Step-child (submit copy of birth certificate)

Other: (Please explain) _____

Marital Status: (Check One) Married Single

Does this dependent reside outside your household? YES NO

If yes, please indicate the address: _____

Last: First: Middle: Suffix:

Social Security Number: - -

Date of Birth: - - Sex: Male Female

Relationship to Participant: (Select One) Spouse (submit copy of marriage certificate) Biological Child (submit copy of birth certificate) Step-child (submit copy of birth certificate)

Other: (Please explain) _____

Marital Status: (Check One) Married Single

Does this dependent reside outside your household? YES NO

If yes, please indicate the address: _____

Last: First: Middle: Suffix:

Social Security Number: - -

Date of Birth: - - Sex: Male Female

Relationship to Participant: (Select One) Spouse (submit copy of marriage certificate) Biological Child (submit copy of birth certificate) Step-child (submit copy of birth certificate)

Other: (Please explain) _____

Marital Status: (Check One) Married Single

Does this dependent reside outside your household? YES NO

If yes, please indicate the address: _____

I certify that all of the information provided is true and correct.

Participant's Signature _____ **Date** _____

**Please Submit Form to:
Zenith American Solutions
2 Gateway Center
603 Stanwix Street, Suite 1500
Pittsburgh, PA 15222-1534**