AFL-CIO HEALTH & WELFARE FUND – ENROLLMENT APPLICATION

Return to: *AFL-CIO Health & Welfare Fund*
333 West Vine Street, Suite 500
Lexington, KY 40507
859-226-1719 or 877-423-5246 / Fax 859-226-1726

Applicant: *Please Read & Complete (Do Not Complete Shaded Areas)*

Employer Name:	Hire Date:
	Date of Retirement:

Date of Union Membership (if applicable):	Social Security Number:

Annual Salary:	Name-Last	First	MI	Date of Birth:	Gender: ☐ Male ☐ Female

Status: ☐ Single ☐ Married ☐ Divorced ☐ Other (please specify):	Home Address-Street	City	State	Zip
	County:	Home Telephone:	☐ Active Employee ☐ Retired Employee ☐ Surviving Spouse ☐ COBRA	

Plan Variation/Sub	Reporting Code/Branch	Group #

List dependents by name. If additional space is required attach a separate sheet.			Date of Birth	Sex	Full-time student	Relationship (spouse, daughter, son, step-child, grandchild, domestic partner, legal guardianship)	Social Security Number
Last	First	MI		M/F	Y/N		

After enrolling in the above coverage will you or any of your dependents have any other health insurance coverage? ☐ YES ☐ NO
If "Yes" please complete the following (include Medicare, Medicaid, private or group coverage) PLEASE PROVIDE COPY OF INSURANCE CARD.

Name of Policyholder	Policy #	Effect. Date	Term Date	Single/ Family	Name & Address of Insurance Co.
Employee					
Spouse					
Dependent					

If covered under Medicare give effective dates for: Part A _____ Part B _____

Please sign and date below. If extra space is needed for any section, attach an additional sheet.

I authorize those providing services to me or my dependents to release relevant information or medical records to insurers, service providers or authorized representatives of the AFL-CIO Health & Welfare Fund.

I have read, or have had read to me, all information contained in this form and such information is accurate and complete to the best of my knowledge. I understand that if I have made any material false statement, misrepresentation or omission on this form which changes the risk assumed by the AFL-CIO Health & Welfare Fund, I may lose coverage under this Plan. I understand that the benefits for which I (we) will be eligible are those described in the Summary Plan Description.

Employee Signature	Date