AFL-CIO HEALTH & WELFARE FUND – CHANGE FORM

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

Group #:	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		Home Address-Street	County
☐ Single ☐ Married ☐ Divorced ☐ Surviving Spouse	☐ Check here if this Is a change of address.	City State	Zip

Change My Present Coverage To: ☐ Employee ☐ Employee Plus 1 Dependent ☐ Family

Change My Name:
From To

Check One		List dependents by name. If additional space is required attach a separate sheet.			Date of Birth			Relationship (spouse, son, daughter, step-child)	Social Security #	Date of Event		
Add	Re-move	Last	First	MI	M	D	Y			M	D	Y

If Adding or Removing a Dependent, check the appropriate reason and provide date:

☐ Married Date:	☐ Newborn Date:
☐ Deceased Date:	☐ Adoption Date:
☐ Divorced Date:	☐ Legal Guardianship Date:

Other Information – Please Explain:

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	Social Security #	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 _____

Have you or any of your dependents had a break in health insurance coverage for more than 63 days prior to enrolling in your employer health plan?
☐ YES ☐ NO IF NO, in order to give you the correct credit for Preexisting Coverage time periods accumulated PLEASE ATTACH THE CERTIFICATE OF COVERAGE FROM YOUR PRIOR HEALTH INSURANCE COVERAGE. IF YOU FAIL TO PROVIDE A CERTIFICATE OF COVERAGE, YOUR FUTURE CLAIMS MAY BE DENIED AS TREATMENT OF PREEXISTING CONDITION.

I certify the above statements to be true and that any dependents listed are my dependents within the definition contained in the group plan. I agree to notify the plan, if and when there is a change in any dependent's status. I authorize any physician, hospital, insurer, or other organization or person having any records, data, or information concerning health history or medical insurance for me or my family members to furnish such records, data or information as may be requested. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee Signature	Date