

# AFL-CIO HEALTH & WELFARE PLAN – IRON WORKERS

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



## CHANGE FORM

*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 <input type="checkbox"/> Male <input type="checkbox"/> Female		
Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Surviving Spouse		<input type="checkbox"/> Check here if this is a change of address.		Home Address-Street				County				
				City			State		Zip			
Change My Present Coverage To: <input type="checkbox"/> Employee <input type="checkbox"/> Employee Plus 1 Dependent <input type="checkbox"/> 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:						Other Information – Please Explain:						
<input type="checkbox"/> Married Date:			<input type="checkbox"/> Newborn Date:									
<input type="checkbox"/> Deceased Date:			<input type="checkbox"/> Adoption Date:									
<input type="checkbox"/> Divorced Date:			<input type="checkbox"/> Legal Guardianship Date:									
After enrolling in the above coverage will you or any of your dependents have any other health insurance coverage? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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				