

# 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*



## ENROLLMENT FORM

*Applicant Please Read & Complete*

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"/> Other (please specify):	Home Address-Street			City	State	Zip	
	County:			Home Telephone:		<input type="checkbox"/> Active Employee <input type="checkbox"/> Retired Employee <input type="checkbox"/> Surviving Spouse <input type="checkbox"/> COBRA	
Plan Variation/Sub		Reporting Code/Branch			Group #		
List dependents by name. If additional space is required attach a separate sheet.							
Last			First	MI	Date of Birth	Sex M/F	Full-time student Y/N
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	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 Plan.

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 Plan, 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
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