Toledo Electrical Welfare Fund
Enrollment Form

Return to Fund Office

CHECK ONE: **New Participant** ☐ **Change** ☐ **Add** ☐

Member/Employee Information (please print)

Name _____ **Social Security #** _____

Address _____
Street City State Zip Code

Status: Widow ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐

Sex Male ☐ Female ☐

Race (response optional) **White** ☐ **Hispanic** ☐ **Black** ☐ **Other** _____

Date Married _____ Date of Divorce/Separation _____

Phone Number ( ) _____ ( ) _____ **Birth Date** _____
Home Cell

Email Address _____ **IBEW Card #** _____

Please List All Eligible Spouse/Dependents

First Name	MI	Last (If different than Member)	Relationship to Member (Spouse / Daughter / Son)	Birth Date	Social Security #

Are Spouse/Dependent(s) covered by other Health Insurance? *Spouse must elect coverage thru their employer if available for $100 or less per month (See enclosed brochure)

Name of Insured _____ Policy # _____ Effective Date: _____

Name of Insurance _____

Type of Coverage (check all that apply) Medical ☐ Vision ☐ Prescription ☐ Dental ☐

Name all dependents covered under other insurance: _____

CHECK BOXES BELOW FOR CHANGE: Effective Date of Change: _____

☐ Convert to COBRA ☐ Reinstate Coverage Without Lapse ☐ Change Name/Address
☐ Cancel Coverage ☐ Terminate Employement ☐ Voluntary Withdrawl
☐ Leave of Absence ☐ Other: (Choose From Below) ☐ Other Change (Specify) _____

Add Dependent(s) due to:
☐ Marriage ☐ Court Order ☐ Birth ☐ Adoption ☐ Late Enrollment ☐ Other Reason: _____

Cancel Dependent(s) due to:
☐ Marriage ☐ Divorce ☐ Death ☐ Age Limit ☐ Change in Student Status ☐ Other Reason: _____

I hereby 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 by Toledo Electrical Welfare Fund or their duly authorized representative. A photocopy of this document shall be considered as effective and valid as the original.

I Certify that the dependents listed are my dependents as defined by the Health Care Plan, I agree to notify the Fund office if there is a change in any dependent's status such as divorce, birth of a child, etc.

I further realize that failure to disclose other insurance coverage information or to falsify information to the TEWF is considered a fraudulent act against the Fund. A fraudulent act may result in denial of eligibility under the benefit plans.

Sign Here _____
Member/Employee Signature Date

Mail To: Toledo Electrical Welfare Fund
P.O. Box 60408, Rossford, Ohio 43460
Telephone: (419) 666-4450 Fax: (419) 666-5410