

Toledo Electrical Welfare Fund Re-Enrollment Form

Return to
Fund Office

Member/Employee Information (please print)

Name _____ Last 4 digits of Social Security # _____

Address _____
Street City State Zip Code

Marital Status Single Divorced Sex Male Race (response optional) White Hispanic
 Married Separated Female 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	Birth Date	Last 4 digits of Social Security #	Name of School (if child over age 19)

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 Prescription Medical Dental Vision
(check all that apply)

Name of Employer _____

Please List Primary Care/Specialty Physician(s) - (Physicians you and your family see frequently)

Name of Physician / Address / Phone / Specialty _____

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
Date

Member/Employee Signature

Beneficiary Designation

1) Death Benefit from Health & Welfare Plan \$10,000 benefit plus \$10,000 for Accidental Death & Dismemberment

Primary Beneficiary _____	Percent/Dollar amount to be allocated _____	
Contingent Beneficiary _____	Percent/Dollar amount to be allocated _____	
Contingent Beneficiary _____	Percent/Dollar amount to be allocated _____	
Contingent Beneficiary _____	Percent/Dollar amount to be allocated _____	
Contingent Beneficiary _____	Percent/Dollar amount to be allocated _____	

2) Local No. 8 IBEW Retirement Plan & Trust

Primary Beneficiary _____ (Must be spouse if married)	Percent to be Allocated _____	
Contingent Beneficiary _____	Percent to be Allocated _____	
Contingent Beneficiary _____	Percent to be Allocated _____	
Contingent Beneficiary _____	Percent to be Allocated _____	
Contingent Beneficiary _____	Percent to be Allocated _____	

*Supplemental Life Insurance (bought through VEBA) and Local No. 8 IBEW 401(k) Plan are done through separate forms through the Life Insurance Company and the 401(k) Administrator (Putnam). Contact the Fund office for assistance.

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