IBEW-NECA SOUTHWESTERN HEALTH AND BENEFIT FUND ENROLLMENT FORM

- Print all information
- Enclose Certificates where applicable (marriage, birth, adoption, etc…)
- Sign and Date Form
- Please return FULLY COMPLETED Form and supporting documents to the Fund Office.

FULLY COMPLETED Forms can be mailed, faxed or emailed to:

IBEW-NECA Southwestern Health and Benefit Fund
c/o Zenith American
P O Box 819015
Dallas, TX 75381-9015
Fax: (972) 341-8097
Email: **DallasCA@zenith-american.com**

Enrollments are processed upon receipt of A FULLY COMPLETED Form and supporting documentation such as marriage certificate, birth certificate or adoption court order. *For questions or assistance in completing this Form, please contact the Fund Office at: (800) 527-0320.*

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	MIDDLE	SOCIAL SECURITY NUMBER
			_____-_____-_____

ADDRESS NUMBER AND STREET	CITY	STATE	ZIP

EMAIL ADDRESS:

LOCAL UNION NO.	DATE OF BIRTH (MM/DD/YYYY)	TELEPHONE NUMBER(S)	EMPLOYEE IDENTIFIES AS:	MARITAL STATUS:
			☐ MALE ☐ FEMALE	Single (S): _____ Separated (SE): _____ Married (M): _____ Widowed (W): _____ Divorced (D): _____ *Please provide effective date(s):* *Status: _____ Date: _____/_____/_____* *Status: _____ Date: _____/_____/_____*

BENEFICIARY DESIGNATION

I hereby designate to receive any death benefit payable under the Health &Welfare fund to the following individual(s). If naming more than one (1) individual, the percentages must total 100%.

FIRST BENEFICIARY'S FULL NAME (FIRST, MI, LAST)	SOCIAL SECURITY NUMBER		PERCENTAGE
	_____-_____-_____		
FIRST BENEFICIARY'S STREET ADDRESS	**CITY**	**STATE**	**ZIP**
SECOND BENEFICIARY'S FULL NAME (FIRST, MI, LAST)	**SOCIAL SECURITY NUMBER**		
	_____-_____-_____		
SECOND BENEFICIARY'S STREET ADDRESS	**CITY**	**STATE**	**ZIP**

CONTINUED ON BACK …

IBEW-NECA SOUTHWESTERN HEALTH AND BENEFIT FUND ENROLLMENT FORM

Page 2 – Enrollment Form – Print Participant Name: _____

ELIGIBLE DEPENDENTS

Eligible dependents include your legal spouse and children (natural, adopted, step). For a more detailed explanation of an Eligible dependent, please refer to page 64 of the Summary Plan Description. Unless Disabled, your child must be under the age of 26. ***Provide the Social Security Number for each enrolled dependent. Federal regulations require health plans to report the names and Social Security Numbers of every covered individual to the IRS.***

NAME *(FIRST, MI, LAST)*	**BIRTHDATE** *(MM/DD/YYYY)*	**SOCIAL SECURITY #**	**RELATIONSHIP**	**OTHER INSURANCE? (Y/N)**

OTHER INSURANCE INFORMATION

Please complete the table below for each dependent that has Other Insurance.

PRIMARY POLICY HOLDER NAME & COVERED DEPENDENTS *(FIRST, MI, LAST)*	**POLICY HOLDER #**	**INSURANCE CO. NAME**	**PHONE NUMBER**

AUTHORIZATION

The Fund is moving towards providing its Participants and their eligible dependents with electronic information when possible. This will include Summary Plan Descriptions (SPDs), Explanation of Benefits (EOBs), claims decisions and other Important Notices.

By signing below, I am:

- **Confirming that the information I've provided on this Enrollment Form is true and correct; and,**
- **Acknowledging and agreeing to electronic receipt of Plan information (including document files and website links) sent to my above listed email, and waiving the right to receive paper copies, unless I request the same. I agree to update the Fund Office with any changes to my email address.**

_____ _____

EMPLOYEE SIGNATURE DATE