Kentucky Laborers District Council Health & Welfare Fund
* Telephone (800) 598-7330 * 1996 By-Pass South * Lawrenceburg, Kentucky * 40342-9754 * Fax (502) 839-3558 *

ENROLLMENT FORM

NOTE: **All information requested on this Enrollment Form MUST be completed IN FULL and it must be signed and returned to Fund for insurance enrollment. If the Enrollment Form is incomplete in any way, the Fund will not be able to update your records accordingly (i.e., adding dependents, etc.) and the Fund will request that you complete another Enrollment Form.**

FAILURE TO COMPLETE THE ENROLLMENT FORM IN FULL MAY CAUSE A DELAY IN BENEFITS AND/OR COVERAGE.

Dear Member: This form, when completed on both sides in full and signed by the member, will serve as a record of your legal dependents and your beneficiary designation for insurance purposes.

MEMBER INFORMATION:

NAME: Last Name: ______________________ First Name: ________________ Middle Initial: ______

SS#: ______ - _____ - __________ | BIRTHDATE: ____________________ | SEX: Male: ____ Female: ____

HOME PHONE #: (_____) ___________ | CELL PHONE #: (_____) ___________ | EMAIL: ____________________

ADDRESS:
Street or P. O. Box: ____

City: ________________________ State: _____ Zip: ________

MARITAL STATUS: Single: ____ Married: ____ Divorced: ____ Legally Separated: ____

ARE YOU OR YOUR DEPENDENTS COVERED BY ANOTHER MEDICAL INSURANCE PLAN? **Yes_____ No_____**
If "YES", please complete the following:
Name of other plan and Policy #: ______________________________ Effective Date: ___________
Name and Birthdate of the Policy Holder: Name: ____________________________ Birthdate: ______________
Please indicate who is covered under the other insurance: Self______ Spouse______ Children_______

ARE YOU OR YOUR DEPENDENTS COVERED BY MEDICARE? **Yes____ No____ If "YES", please complete the following:**
Give full names of persons covered by Medicare and their Medicare Effective Dates (if more than two, attach information on separate sheet)

Names:	Medicare Effective Dates:

DESIGNATION OF BENEFICIARY:

(Contact Fund on Life Insurance Benefit available when designating multiple beneficiaries so you may determine how you wish to disperse that benefit.)

BENEFICIARY'S NAME	RELATIONSHIP TO MEMBER	BENEFICIARY'S ADDRESS (Street or P.O. Box, City, State, Zip)	BENEFICIARY'S PHONE #	LIFE AMOUNT DESIGNATED *

* IF THERE ARE MULTIPLE BENEFICIARIES, PLEASE SHOW AMOUNT OR PERCENTAGE OF LIFE BENEFIT THAT YOU WISH TO DESIGNATE TO EACH BENEFICIARY. NOTE: IF YOU WISH TO LIST MORE THAN TWO BENEFICIARIES, PLEASE ATTACH A LIST, GIVING ALL INFORMATION REQUESTED ABOVE FOR EACH BENEFICIARY LISTED AND SIGN AND DATE THAT LIST

YOU MUST COMPLETE DEPENDENT INFORMATION ON THE REVERSE SIDE OF THIS FORM AND SIGN AND DATE THE FORM

DEPENDENTS:

This includes legally married spouse, unmarried children, stepchildren and legally adopted children.

Please note the following regarding documents are required for enrollment of dependents:

DEPENDENT SPOUSES:

1. You **MUST** submit a copy of your marriage certificate.
2. In the event you and/or your spouse have divorced or legally separated, you **MUST** submit copies of all legal documents (i.e., divorce decree, legal separation orders, etc.)

   NOTE: If you do not submit written notice to the Fund regarding legal separation or divorce (including copies of legal separation documents or divorce decree) within 60 Days of the date of the legal separation or divorce, you may be financially responsible for any claims incurred after said date that are paid by the Fund.

DEPENDENT CHILDREN:

1. You **MUST** submit copies of your dependent children's birth certificates.
2. If you and/or your spouse have divorced or legally separated or are divorced or legally separated from another individual and you wish to enroll dependent children, you **MUST** submit all legal documentation including Divorce Decree and Qualified Medical Child Support Order (QMCSO)
3. If you wish to add an Adult Dependent Child, age 19 to 26 years of age, you **MUST** complete an Adult Dependent Enrollment Form in full and sign it and return it to the Fund Office before the Fund will determine if that dependent will be considered as eligible for dependent coverage.

NOTE: **The Fund may require additional or other documentation to determine eligibility.**

Dependents will not be enrolled if you fail to submit the aforementioned documentation and/or fail to complete the information below IN FULL on each dependent:

DEPENDENT'S FULL NAME (First Name, Middle Initial, Last Name)	SOCIAL SECURITY NUMBER	RELATIONSHIP TO PARTICIPANT	BIRTHDATE

NOTE: **IF THERE ARE MORE DEPENDENTS THAN YOU HAVE LISTED ABOVE, PLEASE ATTACH A LIST GIVING ALL INFORMATION REQUESTED ABOVE FOR EACH BENEFICIARY LISTED AND SIGN AND DATE THAT LIST**

TO BE COMPLETED BY NON BARGAINING UNIT EMPLOYEES OF CONTRIBUTING EMPLOYERS:

Name of Employer ______________________ Local # ________ Job Title: ____________________

I certify that all information I have given on this form is true and complete to best of my knowledge and belief. I understand false statements or incomplete answers may cause employee and/or dependent coverage to be terminated. I understand it is my responsibility, and that of each person named, to immediately notify Fund if any information provided on this form changes for any reason. I will notify Fund if any person listed above becomes eligible for other group medical insurance coverage or Medicare.

MEMBER SIGNATURE ______________________ **DATE SIGNED** ____________________

When calling or corresponding with Health & Welfare Office, you must have insured's name and Social Security Number available. **Please notify this office of any changes in your address, dependents, beneficiary or marital status.**