Health and Welfare Plan Enrollment Application

The CLT&E Health and Welfare Plan is designed to protect you from unexpected medical expenses which could create a severe financial hardship for you and your family. As a Member of this Plan, you may also enroll your eligible dependents, provided you complete the attached Enrollment Form and establish the proper dependency relationship.

In order to establish this dependency relationship, participants are required to provide the following information and documentation.

1. **A completed Enrollment Form, Beneficiary Card and HIPAA Release Form.**
2. **A certified copy of the Marriage License, bearing an official State seal.**
3. **A certified copy of the Birth Certificate for yourself, your spouse, and each eligible dependent to be enrolled.**
4. **Copies of signed Social Security Cards for yourself, your spouse and each eligible dependent to be enrolled (infants do not need to sign their Social Security Cards).**
5. **A copy of the participants' and spouses' signed Federal Tax return (Form 1040 or 1040EZ) for the past two years.**

AND, IF APPLICABLE…

- **A) A copy of the Court Order or Decree establishing any paternity, marriage dissolution, or child support order or obligation.**
- **B) A copy of the Court Order, Decree or Certification of Adoption.**
- **C) A copy of the Court Order establishing guardianship.**
- **D) A copy of the Court Order for foster care placement.**
- **E) A certified statement from a School Registrar's Office,**
- **F) Information pertaining to other insurance, if any.**

The administrative Fund Office may require other documentation or evidence as is necessary to establish the relationship between the eligible participant and the claimed dependent. No claim for benefits for dependents will be processed until all requested information and documentation has been furnished to the Contractors, Laborers, Teamsters and Engineers Fund Office.

The Fund Office may in its sole discretion accept other documentations or forms of verification in lieu of the above items.

Health and Welfare Plan Enrollment Form

MEMBER'S NAME: _____ SSN: _____

DATE OF BIRTH: _____ HOME/CELL PHONE #: _____

MEMBER'S ADDRESS: _____

_____

NAME OF OTHER INSURANCE (If any): _____

POLICY # _____
(Please provide a copy of the insurance card if applicable)

SPOUSE

NAME OF SPOUSE: _____

SSN: _____ DATE OF BIRTH: _____

ADDRESS: _____
(If different than the Member's)

_____

NAME OF OTHER INSURANCE (If any): _____

POLICY # : _____
(Please provide a copy of the insurance card if applicable)

DEPENDENT

NAME OF DEPENDENT: _____

SSN: _____ DATE OF BIRTH: _____

ADDRESS: _____
(If different than the Member's)

_____

NAME OF OTHER INSURANCE (If any): _____

POLICY # : _____
(Please provide a copy of the insurance card if applicable)

Signed by: (Member's Signature): _____ Date:_____

*Please list additional dependents on the reverse side and/or additional sheets of paper.

DEPENDENT

NAME OF DEPENDENT: _____

SSN: _____ DATE OF BIRTH: _____

ADDRESS: _____
(If different than the Member's)
_____

NAME OF OTHER INSURANCE (If any): _____

POLICY # : _____
(Please provide a copy of the insurance card if applicable)

DEPENDENT

NAME OF DEPENDENT: _____

SSN: _____ DATE OF BIRTH: _____

ADDRESS: _____
(If different than the Member's)
_____

NAME OF OTHER INSURANCE (If any: _____

POLICY # : _____
(Please provide a copy of the insurance card if applicable)

DEPENDENT

NAME OF DEPENDENT: _____

SSN: _____ DATE OF BIRTH: _____

ADDRESS: _____
(If different than the Member's)
_____

NAME OF OTHER INSURANCE (If any: _____

POLICY # : _____
(Please provide a copy of the insurance card if applicable)