Twin City Iron Workers Health & Welfare Fund

3001 Metro Drive – Suite 500 | Bloomington, MN 55425 | 952.854.0795 | 800.535.6373

Dear Participant:

Each calendar year it is necessary to update our records for this office. Please provide us with the following information in lieu of a claim form, for each member. During the year, you may also be required to complete a claim form(s) if a bill is received that appears to be accident related.

Insured's Data

Name:	Social Security Number:
Date of Birth:	Phone Number:
Address:	Marital Status: ☐ Single ☐ Married ☐ Divorced Date of Marriage or Divorce: _____
Email:	Employer:

Spouse's Data

Name:	Social Security Number:
Date of Birth:	Phone Number:
Spouse's Employer Name:	Employer's Address:
Employer's Phone Number:	

Spouse's Insurance Data

Does your spouse have other Group Medical Coverage? ☐ Yes ☐ No	If yes, is the coverage type: ☐ Single or ☐ Family
Medical Insurance Carrier Name:	Insurance Carrier Phone Number:
Insurance Carrier Address:	Group Contract Number: Effective Date:_____ Term Date: _____
Does coverage include Dental? ☐ Yes ☐ No	Does coverage include Vision? ☐ Yes ☐ No

Please provide the complete names and birth dates, etc., for all covered dependents. If a dependent child is employed and/or has other insurance, please include that information. To add your dependent children please attach their birth certificate. If you are married, please attach a copy of your marriage certificate. If there is a divorce decree that addresses medical coverage for any dependent children, please supply a copy of that decree.

Dependent's Name	Relationship	DOB	Soc. Sec. No.	Sex	Employer/Other Insurance

If any of the information changes during the calendar year, you must advise us immediately

OVER

Medicare Information including Medicare Part D - Prescription Drug Program

Your Name:_____ Date of Birth _____ /_____ /_____ Medicare HIC #: _____

Effective Date: Part A: _____ /_____ /_____ Part B: _____ /_____ /_____ Part D: _____ /_____ /_____

Spouse's Name:_____ Date of Birth _____ /_____ /_____ Medicare HIC #: _____

Effective Date: Part A: _____ /_____ /_____ Part B: _____ /_____ /_____ Part D: _____ /_____ /_____

If you are retired, please indicate retirement date: You: _____ /_____ /_____

Do you have Medicare due to:
❑ End-stage renal disease and/or ❑ disability ? Effective Date: _____ /_____ /_____

Does your spouse have Medicare due to
❑ End-stage renal disease and/or ❑ disability ? Effective Date: _____ /_____ /_____

Life-Changing Events

If you get married, provide the Fund Office with:
• A copy of your marriage certificate
• Your spouse's date of birth
• A copy of your spouse's medical insurance information, if he or she is covered under another plan

If you add a child, provide the Fund Office with:
• The birth certificate, effective date of adoption papers, court order, or marriage certification (for stepchildren)
• A copy of your child's other medical insurance information, if he or she is covered under another plan

If you get legally separated or divorced, provide the Fund Office with:
• A copy of your separation or divorce decree
• A copy of any QDRO
• If you have children for whom you do not have custody, a copy of any QMCSO

If your spouse wants to continue coverage, he or she must:
• Contact the Fund Office; and
• Enroll for COBRA Continuation Coverage

We are pleased to be of service to you. Please contact this office if you have any questions.

Please sign below, verifying that the above statements are true to the best of your knowledge and belief. Your Signature will also authorize an institution or physician to release information concerning your enrollment, related records and medical records to the fund office, if needed.

_____ _____

Participant's Signature *Date of Signature*