LOCAL 434 HEALTH & WELFARE FUND
PARTICIPANT AND DEPENDENT INFORMATION FORM

To ensure that you and eligible family members receive all the benefits to which you are entitled, we require the following information. Prompt response will eliminate unnecessary delays in claims processing. Please return this form in the enclosed envelope to: Wilson-McShane Corporation, 3001 Metro Drive – Suite 500, Bloomington MN 55425. ***PLEASE PRINT.***

PARTICIPANT INFORMATION:

Participant Name: ______________________________ Birth Date: ____/____/____

Mailing Address: ______________________________

City: ______________________ State: ______ Zip Code: ______________

Social Security Number: ______-______-______ Telephone: (______)______-______

Marital Status: ☐Single ☐Married (Date:____/____/____) ☐Widowed (Date: ____/____/____)

☐ Divorced (Date:____/____/____) ☐ Legally Separated (Date: ____/____/____)

SPOUSE INFORMATION: (Copy of Marriage Certificate Required)

Spouse's Full Name: ______________________________ Birth Date: ____/____/____

Social Security Number: ______-______-______

Is your spouse employed? ☐ No ☐ Yes Does your spouse have other group coverage? ☐ No ☐ Yes; **if yes, please complete the following:**

Medical and Prescription Drugs: Insurance company or plan name and address: ______________________________

____

Coverage: ☐ Single ☐ Family; Group Number: ______________ Subscriber Number: ______________

Dental: Insurance company or plan name and address: ______________________________

____

Coverage: ☐Single ☐Family; Group Number: ______________ Subscriber Number: ______________

Vision: Insurance company or plan name and address: ______________________________

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Coverage: ☐Single ☐Family; Group Number: ______________ Subscriber Number: ______________

ELIGIBLE DEPENDENT INFORMATION:

Do you have unmarried children or stepchildren under age 25 who are legally declared as dependents on your federal income tax return?

☐ Yes. *Please read and sign at the bottom of this page* ***and complete the back of this form.***

☐ No. *Please read and sign at the bottom of this page. You do not need to complete the back of this form.*

I certify that the information contained on both sides of this form is true and correct. I agree to promptly notify **Wilson-McShane Corporation, 3001 Metro Drive, Suite 500, Bloomington, MN 55425** in writing in the event of: 1) a change in marital status due to marriage, death, divorce or legal separation; 2) the death or disability of any other person named on this form; 3) the birth or adoption of a dependent child, or the addition of a stepchild, due to marriage; and 4) a child's dependent status changes due to age, student status, marriage, financial dependency on someone else or financial independence.

Signature: ______________________________ Date: ______________

ELIGIBLE DEPENDENT INFORMATION: (Copy of each dependents birth certificate required)

Last Name (if different than Participant's last name)	**First Name**	**M.I.**	**Relationship: Natural, step or adopted child**	**Sex**	**Birth Date**	**Social Security No.**
			☐ Natural ☐ Step ☐Adopted	M F	/ /	- -
			☐ Natural ☐ Step ☐Adopted	M F	/ /	- -
			☐ Natural ☐ Step ☐Adopted	M F	/ /	- -
			☐ Natural ☐ Step ☐Adopted	M F	/ /	- -
			☐ Natural ☐ Step ☐Adopted	M F	/ /	- -
			☐ Natural ☐ Step ☐Adopted	M F	/ /	- -

List the names and address(es) of any above named children who do <u>not</u> reside with you. Names:____

Address: ____

☐ Do you claim each of these children on your Federal tax return? Yes No; if not, which children and why: ____

____

☐ Are you responsible for providing medical coverage for these children? No Yes; **if you are divorced, legally separated or required by some other type of court order to provide coverage for these children, please attach a copy of the divorce decree or other legal documentation.**

☐ Are these children covered under any other group insurance coverage (other than your spouse's coverage listed on the front of this form)? No Yes; if so, please complete the following:

Insured's Name: ________________________________ Child(ren)'s Name(s): ____

☐ **Medical:** Insurance company or plan name and address: ____

☐ Coverage: Single Family; Group Number: _________________________ Subscriber Number: ______________________________________

☐ **Dental:** Insurance company or plan name and address: ____

☐ Coverage: Single Family; Group Number: _________________________ Subscriber Number: ______________________________________

☐ **Vision:** Insurance company or plan name and address: ____

☐ Coverage: Single Family; Group Number: _________________________ Subscriber Number: ______________________________________