FAMILY INFORMATION FORM

RETURN COMPLETED FORM TO: ⟹ PREVENT DELAY ANSWER ALL QUESTIONS

Sheet Metal Workers Local 270
Health & Welfare Fund
1863 N. 105th E. Ave
Tulsa OK 74116
(918)587-2388 Fax(918)587-2442

This form must be completed and signed by the member before any claims will be processed. All questions must be answered.

❑ ***Change of Address***

SECTION ONE - MEMBER INFORMATION

Name	Mailing Address	City, State & Zip Code	
Date of Birth	Social Security Number	Home Phone Number	Local Union #

Are you covered under any other Medical, Dental, Vision, or Prescription Plan(s)? ❑Yes ❑ No

Check all that apply ❑ Medical ❑ Dental ❑ Prescription
If Yes, you must complete Section 3 (insurance information)

Medicare ❑Yes ❑ No

SECTION TWO - SPOUSE INFORMATION

Spouse Name	Date of Birth	Social Security No. *See Below
Spouse Address		

Sex ❑ Male ❑ Female	Name & Address of Employer	Is spouse covered under any other Medical, Dental, Prescription or MedicarePlan(s)? ❑ Yes ❑ No Check all that apply ❑ Medical ❑ Dental ❑ Prescription ❑ Medicare If Yes, you must complete Section 3 (insurance information)

SECTION THREE - OTHER INSURANCE INFORMATION

Name of Insured	Insured's ID Number
Policy or Plan No.	Type of Coverage: ❑ Individual ❑ Group
Name, Address and Phone No. Of Insurance Co.	Name(s) of Family Members Covered Under Other Insurance.

THIS FORM MUST BE DATED AND SIGNED BY YOU AND YOUR SPOUSE

I/We jointly certify that the above information is true and correct. I/We hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish Sheet Metal Workers' Local 270 Welfare Fund with full information regarding treatment rendered (including copies of their records). I/We also authorize any union, trust fund, employer or insurance carrier to furnish Sheet Metal Workers' Local 270 Welfare Fund with information regarding benefits to which I/we may be entitled. A copy or photocopy of this authorization shall be considered as effective and valid as the original.

DATE	MEMBER'S SIGNATURE	SPOUSE'S SIGNATURE

On back of this form, please provide the requested information On all family members who are covered under the Plan.

*** Due to recent governmental reporting requirements, Social Security Numbers, and if applicable, Medicare ID numbers are required**

Dependents Name	Date of Birth	Social Security No. *See Below

Dependents Address

Relation to Member	Sex
❑ Child	❑ Male
❑ Step Child	❑ Female

Is child living with you? ❑ Yes ❑ No

Full time student? ❑ Yes ❑ No

Full-time College Student must have an official letter of attendance from the school.

Is dependent covered under any other Medical, Dental, Prescription or Medicare Plan(s)?

❑ Yes ❑ No

If different from other insurance indicated in Section 3 on the front of this Form, check all that apply: ❑ Medical ❑ Dental ❑ Prescription ❑ Medicare

If Yes, you must complete the following:

Name of Insured ______________________ Group or Plan Number

Insured's ID No. ______________________ Type of Coverage ❑Group ❑Individual

Name, address & phone number of other Insurance Co.

Dependents Name	Date of Birth	Social Security No. *See Below

Dependents Address

Relation to Member	Sex
❑ Child	❑ Male
❑ Step Child	❑ Female

Is child living with you? ❑ Yes ❑ No

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Is dependent covered under any other Medical, Dental, Prescription or Medicare Plan(s)?

❑ Yes ❑ No

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Insured's ID No. ______________________ Type of Coverage ❑Group ❑Individual

Name, address & phone number of other Insurance Co.

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