IBEW LOCAL 236 HEALTH & BENEFIT FUND ENROLLMENT FORM

PARTICIPANT NAME (FIRST NAME + MI + LAST NAME)	**SOCIAL SECURITY #**	**GENDER** ☐ MALE ☐ FEMALE	**DATE OF BIRTH (MM/DD/YY)**	
MAILING ADDRESS (STREET, APT NO.)	**CITY**	**STATE**	**ZIP CODE**	**TELEPHONE** ( ) -
EMAIL ADDRESS:	**MARITAL STATUS:** **___SINGLE ___MARRIED**	**CLASSIFICATION:** **CE / CW**		

WHICH PLAN TYPE(S) & COVERAGE AMOUNT(S) ARE YOU ENROLLING IN?

MEDICAL INSURANCE:

CDPHP - Hybrid PPO $30/$50

_____SINGLE _____2-PERSON _____FAMILY _____WAIVE/OPT OUT

INFORMATION ABOUT FAMILY PARTICIPANTS YOU WANT ENROLLED UNDER YOUR PLAN: (for additional dependents please attach another page, Proof of Marriage and Birth Certificates are required if adding spouse or dependent child(ren))

NAME (First Name + MI + Last Name)	**ELECTING COVERAGE**	**WAIVING COVERAGE**	**SOCIAL SECURITY NUMBER**	**DATE OF BIRTH**	**GENDER**
SPOUSE NAME:	**_____HEALTH**	**_____HEALTH**			
DEPENDENT NAME:	**_____HEALTH**	**_____HEALTH**			
DEPENDENT NAME:	**_____HEALTH**	**_____HEALTH**			
DEPENDENT NAME:	**_____HEALTH**	**_____HEALTH**			
DEPENDENT NAME:	**_____HEALTH**	**_____HEALTH**			
DEPENDENT NAME:	**_____HEALTH**	**_____HEALTH**			
DEPENDENT NAME:	**_____HEALTH**	**_____HEALTH**			
DEPENDENT NAME:	**_____HEALTH**	**_____HEALTH**			

PARTICIPANT CERTIFICATION:

I *hereby certify that the above information is correct. I further certify that I have read and agree to these Terms and Conditions:* I, the above named participant, hereby authorize the elected benefit premiums noted above until such time as I should provide written notice to change or discontinue these deductions/reductions. I also authorize the Plan Administrator to make any future adjustments necessary should there be a change in the premium amounts for the coverage options I have selected. I agree to notify the Plan Administrator in writing of any changes to my personal information above that may affect the administration of my benefits. I understand that neither my employer nor the Plan Administrator will be held liable for any delays or problems in the administration of my Plan in the event that I fail to provide them with this information in an accurate and timely manner.

IBEW LOCAL 236 PARTICIPANT NAME	**IBEW LOCAL 236 PARTICIPANT SIGNATURE**	**DATE SIGNED**

For any questions you may have regarding completing this form or additional information that may be required contact the IBEW Local 236 Health & Benefit Fund (518) 782-5499 or Jaeger & Flynn Associates (JFA) (800) 388-8538. Please forward the completed form to the IBEW Local 236 Health & Benefit Fund at 3000 Troy Schenectady Rd., Schenectady, NY 12309-1614. Thank you.

TO BE COMPLETED BY IBEW LOCAL 236 HEALTH & BENEFIT FUND OFFICE:

Benefit Effective Date:_____ **Insurance Code_____**

Fund Office Signature:_____ **Date Signed:_____**