UNITED FOOD AND COMMERCIAL WORKERS UNION
AND PARTICIPATING FOOD INDUSTRY EMPLOYERS
TRI-STATE HEALTH AND WELFARE FUND

800-228-7484 856-793-2500 Fax- 1-856-793-3100

HEALTH INSURANCE COVERAGE INFORMATION FORM

SECTION I ⇨ PLEASE COMPLETE THE FOLLOWING INFORMATION (print or type):

LAST NAME	FIRST NAME	MIDDLE INITIAL	☐ Male ☐ Female

STREET ADDRESS	APT. NO.
CITY, STATE, ZIP CODE	DATE OF BIRTH

HOME PHONE NUMBER ( )	SOCIAL SECURITY NUMBER	EMPLOYER	LOCAL UNION NUMBER

PRESENT STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Other (explain on reverse side)

LIST BELOW NAME(S) OF YOUR SPOUSE AND ELIGIBLE DEPENDENT CHILDREN (use reverse side if necessary)

NAME First	NAME Last (if different)	SEX	BIRTHDATE MO	BIRTHDATE DAY	BIRTHDATE YR	CHECK RELATIONSHIP	CHECK IF A *CHANGE*	SOCIAL SECURITY NUMBER
						☐ Husband ☐ Wife	☐	
						☐ Child ☐ Stepchild	☐	
						☐ Child ☐ Stepchild	☐	
						☐ Child ☐ Stepchild	☐	

SECTION II ⇨ PLEASE COMPLETE THE FOLLOWING INFORMATION:

1. **Do you have other medical coverage available through another source?** ☐YES ☐NO

   If YES, please check box ☐ Spouse ☐Parent ☐Other
   If you <u>do</u> have other Medical Benefits, please list the name of the insurer.

   _____ INSURANCE COMPANY _____ EFFECTIVE DATE _____ EMPLOYER

2. **Does your spouse or children have medical coverage through another source?** ☐YES ☐NO

   If YES, please check box ☐ Spouse ☐Parent ☐Other Employer
   If you <u>do</u> have other Medical Benefits, please list the name of the insurer.

   _____ INSURANCE COMPANY _____ EFFECTIVE DATE _____ EMPLOYER

3. **Were you offered or do you have the opportunity to purchase other Group Health Insurance?** ☐YES ☐NO

   If YES, please check : ☐ Spouse ☐Parent ☐other

   Approximate cost weekly $_____ Approximate cost monthly $_____

SECTION III ⇨ PLEASE SIGN AND RETURN THIS FORM IN THE ENCLOSED SELF-ADDRESSED ENVELOPE IMMEDIATELY:

_____ _____

YOUR SIGNATURE **DATE**