# Dependent Information Form

Member Name _____ Social Security # _____

Address _____ City _____ Zip Code _____

Date of Birth _____ Telephone Number _____

Spouse Name _____ Date of Birth _____ Social Security # _____

***** If married please provide marriage certificate *****

## List All Dependent Children Under Age 26

Name _____ Date of Birth _____ Social Security # _____

Name _____ Date of Birth _____ Social Security # _____

Name _____ Date of Birth _____ Social Security # _____

Name _____ Date of Birth _____ Social Security # _____

**Are your dependents covered by other medical insurance?**

**If yes, please provide the following:**

Name of Insurance _____

Type of Coverage: Medical: _____ Hospital: _____ Dental: _____ RX Plan: _____

Member Signature _____

****Please provide copies of birth certificates and social security card for all of your dependents.****

**In order to provide you with the best service possible, please answer the following questions with regard to your spouse's employment and medical insurance coverage:**

**1. Is your spouse employed? Yes_____ No_____**

**If yes, name and address of your spouse's employer:**

_____
Name of employer

_____
Address

_____
City State Zip Code

**2. Does your spouse's employer provide medical insurance? Yes_____ No _____**

**If yes, name of insurance carrier: _____**

**Insurance identification #: _____ Effective date of coverage: _____**

**Type of coverage:** **Individual: _____ Family: _____**

**Medical: _____ Hospital: _____ Dental: _____ RX Plan: _____**

_____
Member Name Social Security #

_____
Member Signature

_____
Spouse Name Social Security #

_____
Spouse Signature

****Please return this completed form to the fund office within 15 days so that we may expedite the processing of claims and determine if benefits are available. Failure to return this form may cause a delay in payment of claims incurred.****