Laborers' District Council of the Metropolitan Area of Philadelphia and Vicinity

Laborers' District Council Benefit Funds Enrollment Form

525-M

INSTRUCTIONS:
- **ALL MEMBERS MUST COMPLETE SECTIONS 1, 2, AND 4.**
- **ALL MEMBERS WITH FAMILY COVERAGE MUST ALSO COMPLETE SECTION 3.**
- **ALL MEMBERS MUST SIGN SECTION 5 OF THIS FORM.**

SECTION 1

PURPOSE OF FILING THIS FORM: ☐ New Member ☐ Dependent Add/Drop ☐ Name Change ☐ Change of Address or Phone #

FIRST NAME	MI	LAST NAME		MEMBER'S SOCIAL SECURITY NUMBER	MEMBER'S DATE OF BIRTH MONTH DAY YEAR
STREET ADDRESS				MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED	
P.O. BOX RURAL ROUTE				MEMBER'S GENDER ☐ MALE ☐ FEMALE	
CITY	STATE	COUNTRY	ZIP CODE	SPOUSE'S EMPLOYER	SPOUSE'S SOCIAL SECURITY NUMBER
HOME PHONE NO.		CELLPHONE NO.		E-MAIL ADDRESS	ALTERNATIVE PHONE NO.

SECTION 2

MEMBER OF:
☐ LABORERS' LOCAL 57 ☐ LABORERS' LOCAL 135 ☐ LABORERS' LOCAL 332 ☐ LABORERS' LOCAL 413 ☐ OTHER ____________

TYPE OF COVERAGE ☐ INDIVIDUAL ☐ FAMILY (LIST ELIGIBLE DEPENDENTS IN SECTION 3 BELOW)

Are you covered by Medicare .... **Part A** ☐ Yes ☐ No **Part B** ☐ Yes ☐ No
Is your spouse covered by Medicare .... **Part A** ☐ Yes ☐ No **Part B** ☐ Yes ☐ No
Are any of your eligible dependents covered by Medicare .... **Part A** ☐ Yes ☐ No **Part B** ☐ Yes ☐ No

LIST ALL DEPENDENTS INCLUDING YOUR SPOUSE AND YOUR CHILDREN WHO HAVE NOT REACHED AGE 26.

SECTION 3

FIRST NAME	MI	LAST NAME	☐ Spouse ☐ Child ☐ Stepchild ☐ Adopted	DATE OF BIRTH MONTH DAY YEAR	DEPENDENT'S SOCIAL SECURITY NUMBER
DEPENDENT'S GENDER ☐ MALE ☐ FEMALE		☐ ADD ☐ DROP		NAME OF SCHOOL/COLLEGE OR EMPLOYER	
FIRST NAME	MI	LAST NAME	☐ Spouse ☐ Child ☐ Stepchild ☐ Adopted	DATE OF BIRTH MONTH DAY YEAR	DEPENDENT'S SOCIAL SECURITY NUMBER
DEPENDENT'S GENDER ☐ MALE ☐ FEMALE		☐ ADD ☐ DROP		NAME OF SCHOOL/COLLEGE OR EMPLOYER	
FIRST NAME	MI	LAST NAME	☐ Spouse ☐ Child ☐ Stepchild ☐ Adopted	DATE OF BIRTH MONTH DAY YEAR	DEPENDENT'S SOCIAL SECURITY NUMBER
DEPENDENT'S GENDER ☐ MALE ☐ FEMALE		☐ ADD ☐ DROP		NAME OF SCHOOL/COLLEGE OR EMPLOYER	
FIRST NAME	MI	LAST NAME	☐ Spouse ☐ Child ☐ Stepchild ☐ Adopted	DATE OF BIRTH MONTH DAY YEAR	DEPENDENT'S SOCIAL SECURITY NUMBER
DEPENDENT'S GENDER ☐ MALE ☐ FEMALE		☐ ADD ☐ DROP		NAME OF SCHOOL/COLLEGE OR EMPLOYER	
FIRST NAME	MI	LAST NAME	☐ Spouse ☐ Child ☐ Stepchild ☐ Adopted	DATE OF BIRTH MONTH DAY YEAR	DEPENDENT'S SOCIAL SECURITY NUMBER
DEPENDENT'S GENDER ☐ MALE ☐ FEMALE		☐ ADD ☐ DROP		NAME OF SCHOOL/COLLEGE OR EMPLOYER	
FIRST NAME	MI	LAST NAME	☐ Spouse ☐ Child ☐ Stepchild ☐ Adopted	DATE OF BIRTH MONTH DAY YEAR	DEPENDENT'S SOCIAL SECURITY NUMBER
DEPENDENT'S GENDER ☐ MALE ☐ FEMALE		☐ ADD ☐ DROP		NAME OF SCHOOL/COLLEGE OR EMPLOYER	
FIRST NAME	MI	LAST NAME	☐ Spouse ☐ Child ☐ Stepchild ☐ Adopted	DATE OF BIRTH MONTH DAY YEAR	DEPENDENT'S SOCIAL SECURITY NUMBER
DEPENDENT'S GENDER ☐ MALE ☐ FEMALE		☐ ADD ☐ DROP		NAME OF SCHOOL/COLLEGE OR EMPLOYER	

If you wish to drop a dependent, please contact the Fund office before returning this card.

Any fund accepting this card for census enrollment requires that you submit one or all of the following documents to substantiate the dependent status of any individual listed on this card as your dependent:
- Marriage certificate or common law marriage affidavit if common law marriage was established prior to September 17, 2003;
- Birth certificate for each dependent child (must list names of each parent); or domestic court order; or support order;
- Hospital birth record for each newborn child (if no birth certificate is available);
- For step-child(ren), please show: (i) marriage certificate listing the biological parent and (ii) birth certificate listing biological parent;
- For adopted child(ren), please show adoption documentation or birth certificate with member's name.
- For foster child(ren), please provide proof that foster child is a dependent of the participant for support and maintenance and that no other medical insurance is reasonably available to cover such foster child(ren).

Dependent eligibility will be determined by the Fund. You may be required to provide additional proof to confirm the eligibility status of one or all of the above dependents.

MUST COMPLETE AND SIGN REVERSE SIDE

SECTION 4
OTHER COVERAGE

Coordination of Benefits applies when you or any dependent receive benefits under more than one health insurance program. Coordinating benefits helps to contain the cost of health care and can save you some out-of-pocket expenses when balances remain after one carrier has made its claim payment.

OTHER COVERAGE A:

SECTION 4

NAME OF DEPENDENT WITH OTHER COVERAGE FIRST NAME MI LAST NAME		POLICY OR OTHER IDENTIFICATION NO.	DATE OF BIRTH MONTH DAY YEAR	GENDER ☐ MALE ☐ FEMALE
NAME OF OTHER EMPLOYER		ADDRESS OF OTHER EMPLOYER		
NAME OF OTHER INSURANCE CARRIER		ADDRESS OF OTHER INSURANCE CARRIER		
TYPE OF COVERAGE ☐ Individual ☐ Family	BENEFITS PROVIDED ☐ Hospital ☐ Dental ☐ Med/Surgical ☐ Optical ☐ Prescription	PHONE NO. OF OTHER INSURANCE CARRIER		
EFFECTIVE DATE MONTH DAY YEAR		TERMINATION DATE MONTH DAY YEAR		

OTHER COVERAGE B:

SECTION 4

NAME OF DEPENDENT WITH OTHER COVERAGE FIRST NAME MI LAST NAME		POLICY OR OTHER IDENTIFICATION NO.	DATE OF BIRTH MONTH DAY YEAR	GENDER ☐ MALE ☐ FEMALE
NAME OF OTHER EMPLOYER		ADDRESS OF OTHER EMPLOYER		
NAME OF OTHER INSURANCE CARRIER		ADDRESS OF OTHER INSURANCE CARRIER		
TYPE OF COVERAGE ☐ Individual ☐ Family	BENEFITS PROVIDED ☐ Hospital ☐ Dental ☐ Med/Surgical ☐ Optical ☐ Prescription	PHONE NO. OF OTHER INSURANCE CARRIER		
EFFECTIVE DATE MONTH DAY YEAR		TERMINATION DATE MONTH DAY YEAR		

IF DEPENDENTS HAVE ADDITIONAL COVERAGE, PLEASE PROVIDE INFORMATION ON ADDITIONAL SHEETS.

Is the member RETIRED from military service? Yes _____ No _____

SECTION 5

CERTIFICATION

The undersigned Participant hereby certifies that any and all information supplied on this Benefits Enrollment Form is true and correct and understands that coverage may be rescinded for misrepresented information or fraud. I certify that any adult child listed above has not reached the age of 26. Further, in the event of fraud or intentional misrepresentation, the Fund will require you to repay the Plan for the full amount of any benefits improperly received. I further consent and permit the information contained herein to be used by any and all Laborers' District Council Benefit Funds.

Member's Signature _____ Date _____

Please complete and return this form in the enclosed self-addressed envelope.

Please contact Member Services at (877) LABOR-77, (215) 236-6700 or (215) 765-4633 for any questions relating to this form.