PLEASE RETURN THIS FORM TO:
NECA – IBEW 697 C/O Stewart C. Miller & Co., Inc.
2111 West Lincoln Highway, Merrillville, IN 46410
Phone Toll-Free 1-800-759-6944 or 219-769-6944

**INFORMATION UPDATE FOR 2012**
**UNTIL THIS FORM IS RETURNED, CLAIMS WILL NOT BE PAID.**

**IMPORTANT: PLEASE ANSWER ALL QUESTIONS AND SIGN THIS FORM**
**Active_____ Retiree____ Surviving Spouse ____Permanently Disabled___**

| Medicare | Member | Spouse |
|---|---|---|
| | Part A: ___/___/_____ | Part A: ___/___/____ |
| | Part B: ___/___/_____ | Part B: ___/___/____ |

| YOUR NAME | ☐ MALE ☐ FEMALE | DATE OF BIRTH | SOCIAL SECURITY NO. – – | ☐ MARRIED ☐ WIDOWED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED – Date of Divorce____/____/____ |
|---|---|---|---|---|

YOUR ADDRESS – (NO. & STREET) PHONE NUMBER

(CITY) (STATE) (ZIP CODE)

| NAME OF SPOUSE | SPOUSE'S DATE OF BIRTH | SPOUSE'S SOCIAL SECURITY NO. – – | IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO |
|---|---|---|---|

NAME AND ADDRESS OF SPOUSE'S EMPLOYER

DO YOU, OR A FAMILY MEMBER HAVE ANY OTHER INSURANCE? Yes _____ No _____ If Yes, please complete section A through G below:
☐ MEDICAL ☐ DENTAL ☐ VISION ☐ MEDICARE/MEDICAID

| A. NAME OF COMPANY | | | B. WHO IS THE POLICY HOLDER ON THIS INSURANCE? |
|---|---|---|---|
| C. ADDRESS – (NO. & STREET) (CITY) | (STATE) | (ZIP CODE) | D. PHONE NUMBER |
| E. POLICY # | F. GROUP # | | G. EFFECTIVE DATE OF COVERAGE |

| List All Dependent Children | Social Security # | Date of Birth | Relationship | Covered under insurance listed in box A-G, | | Is this Dependent incapacitated? | |
|---|---|---|---|---|---|---|---|
| 1. | | | | ____yes | ____no | ____yes | ____no |
| 2. | | | | ____yes | ____no | ____yes | ____no |
| 3. | | | | ____yes | ____no | ____yes | ____no |
| 4. | | | | ____yes | ____no | ____yes | ____no |
| 5. | | | | ____yes | ____no | ____yes | ____no |
| 6. | | | | ____yes | ____no | ____yes | ____no |
| 7. | | | | ____yes | ____no | ____yes | ____no |

**If any of these dependents are over the age of 18, please complete the reverse side of this form.**

**List any additional Dependents on a separate sheet of paper.

****NOTE: Listing a Dependent(s) is not sufficient to add them to your coverage. Please contact the Benefits Office for the enrollment information.**

Be sure to notify the Benefits Office at 219-845-4433 if any of the following changes occur during 2012:
(a) A change in your address or phone number; (in writing)
(b) A change in your marital status;
(c) A change regarding other insurance (A - G above)
(d) Eligibility for the Federal Medicare Program (if you haven't already done so, a copy of your Medicare card(s) should be sent to the Benefits Office).

I hereby affirm that the above information is a true and correct statement:

Date _____ Signature of Participant/Employee _____

# DEPENDENT ELIGIBILITY FORM

**Please complete this form for any Dependent Child listed who is over the age of 18.**

Child's Name: _____

1. Is this dependent currently working?
   Yes_____ No_____
   - If so, what is the name of his/her employer?

     _____

   1a. In regards to this Employment, is there any available health coverage?
   Yes_____ No_____

   - If yes, did you choose this coverage?
     Yes_____ No_____

   What is the name of the Health Plan/Insurance?

   _____

2. Is this Dependent currently married?
   Yes_____ No_____
   2a. Is he/she covered under the spouse's health coverage? Yes_____ No_____

   - If so, what is the name of their Health Plan/Insurance?

     _____

3. Does this Dependent live at home with you?
   Yes_____ No_____

If not, please forward their current mailing address:

_____
Street Name

_____
City State Zip

_____
Phone Number

Child's Name: _____

1. Is this dependent currently working?
   Yes_____ No_____
   - If so, what is the name of his/her employer?

     _____

   1a. In regards to this Employment, is there any available health coverage?
   Yes_____ No_____

   - If yes, did you choose this coverage?
     Yes_____ No_____

   What is the name of the Health Plan/Insurance?

   _____

2. Is this Dependent currently married?
   Yes_____ No_____
   2a. Is he/she covered under the spouse's health coverage? Yes_____ No_____

   - If so, what is the name of their Health Plan/Insurance?

     _____

3. Does this Dependent live at home with you?
   Yes_____ No_____

If not, please forward their current mailing address:

_____
Street Name

_____
City State Zip

_____
Phone Number

Child's Name: _____

1. Is this dependent currently working?
   Yes_____ No_____
   - If so, what is the name of his/her employer?

     _____

   1a. In regards to this Employment, is there any available health coverage?
   Yes_____ No_____

   - If yes, did you choose this coverage?
     Yes_____ No_____

   What is the name of the Health Plan/Insurance?

   _____

2. Is this Dependent currently married?
   Yes_____ No_____
   2a. Is he/she covered under the spouse's health coverage? Yes_____ No_____

   - If so, what is the name of their Health Plan/Insurance?

     _____

3. Does this Dependent live at home with you?
   Yes_____ No_____

If not, please forward their current mailing address:

_____
Street

_____
City State Zip

_____
Phone Number

I affirm that this information is true to the best of my knowledge.

Member Signature: _____ Today's Date: _____