FAMILY UPDATE FORM

St. Paul Electrical Construction Health Plan

Please provide a copy of Birth or Marriage Certificate where applicable.

Member Information

____
Last Name First Name MI Social Security Number

____
Address City State Zip Code

____
Home Phone (if applicable) Cell Phone e-mail address

____Male ____Female____
Date of Birth Marital Status

Spouse Information

____
Last Name First Name MI Social Security Number

____
Date of Birth Date of Marriage Employer

Dependent Children (Through Age 18)

Full Name	Relationship to Member	Date of Birth	Social Security Number

Dependent Children (Age 19 through 25) Requires Dependent Affidavit Form

Full Name	Relationship to Member	Date of Birth	Social Security Number

Are any of your family members covered by other insurance? Y_____ N_____
If yes, please complete and return the attached Coordination of Benefits payge

Coordination of Benefits

If your spouse or dependent children are covered under other insurance, please complete the following information below.

Medical Insurance Information-YES_____ NO______

Name of Insured:___________________________________ Employer Name:______________________

Insurance Company/Plan Name: ________________________________ Group Number: _______________

Effective Date of Insurance: _____________________________ Term Date of Insurance: ______________

Family coverage: Yes/No
If yes, list covered dependents

____

Dental Insurance Information-YES_____NO______

Name of Insured:___________________________________ Employer Name:______________________

Insurance Company/Plan Name: ________________________________ Group Number: _____________

Effective Date of Insurance: _____________________________ Term Date of Insurance: ____________

Family coverage: Yes/No
If yes, list covered dependents

____

Please attach Certificate of Coverage for any current and/or prior insurance.

Application and or documents that need to be provided may be faxed to 651-294-0344 or mailed to Benefit Office, 1330 Conway St., Ste 130 St. Paul, MN 55106.

I hereby authorize any insurance company, employer, hospital or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this plan. I certify that all information on this application is true and correct to the best of my knowledge. I understand and agree that supplying false or incorrect information may result in a reduction or loss of benefits or may require me to reimburse the Medical Plan for benefits received that I was not eligible for.

SIGNATURE: ____**DATE:**___________________________

Question regarding application please call (651)776-4239 Ext 750 or email REthier@speiasc.org

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