TIERED COVERAGE - SINGLE

St. Paul Electrical Workers Health Plan
Application for Medical Coverage

(Please **print** clearly and complete all information on Application)

Member Information

Last Name | First Name | MI | Social Security Number

Address | City | State | Zip Code

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

Date of Birth | Marital Status | Male ____ Female____

Please provide Certificate of Coverage for any current or prior insurance.

Application and or documents that need to be provided may be faxed to 651-776-9973 or Email: spewbenefits@wilson-mcshane.com 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:**__________________

Employee Complete

Name of Employer: ____________________

Start Date: ____________________

Please Circle your following classification:

Apprentice, **Inside JW**, **LEA**, **Office Worker**

Office Use Only

Effective Date: ____________________

Plan Code: ____________________

Trustee Meeting Date: ____________

Initialed: ____________________

Question regarding application please call (952)851-5949