TIERED COVERAGE-SINGLE + ONE
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 ☐

Spouse Information **(Marriage certificate required for coverage)**

Last Name | First Name | MI | Social Security Number

Date of Birth | Date of Marriage | Employer

Dependent Children (Through Age 18) **(Birth certificate required for coverage, if no spouse is on plan we require Dependent Affidavit form)**

Full Name	Relationship to Member	Date of Birth	Social Security Number

Dependent Children (Age 19 through 25) **(Birth certificate required for coverage Requires Dependent Affidavit Form)**

Full Name	Relationship to Member	Date of Birth	Social Security Number

Employee Complete

Name of Employer: _____

Start Date: _____

Please Circle your following classification:

Office Use Only

Effective Date: _____

Plan Code: _____

Trustee Meeting Date: _____

Initialed:

Please see other side for completion of Medical Application

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 for spouse/dependents and divorce or court decree so coordination of benefits can be determined.

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:**_____

Question regarding application please call (952)851-5949