

## BAC INTERNATIONAL HEALTH FUND HEALTH & WELFARE ENROLLMENT FORM

**POS** \_\_\_\_\_

(Do not write in shaded area)

ACCOUNTING/DIVISION CODE \_\_\_\_\_ PLAN \_\_\_\_\_

<b>CHANGE EFFECTIVE DATE:</b>		<b>LOCAL / LOCATION :</b>
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Medical Group Number: 713869	Dental Group Number: 516220	Vision Group Number: 02109592
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MEMBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH : MO	DAY	YEAR
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ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE
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DATE OF UNION MEMBERSHIP	SOCIAL SECURITY NUMBER	E-Mail Address	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
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OTHER INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	IF MEDICARE ELIGIBLE <input type="checkbox"/> "A" <input type="checkbox"/> "B"	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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<b>MEMBER STATUS:</b> <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Medicare <input type="checkbox"/> COBRA <input type="checkbox"/> Non-Job Site	<b>STATUS CHANGE:</b> From _____ to _____ Date: _____
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Type of coverage : Please check one     Member only     Member + Spouse     Member + Spouse + Child(ren)     Member + Child(ren) only

DEATH BENEFITS TO BE PAID TO : (Full Name)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP	TELEPHONE
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ADDRESS OF BENEFICIARY (Street, City, State, Zip)

**MEDICAL-DENTAL-VISION INSURANCE: subject to the provision of your Local**

I understand that this enrollment form must be completed, signed and returned to the Fund office timely to avoid any delays in coverage. It is unlawful for a participant or dependent(s) or other individual(s) to knowingly and intentionally provide false, incomplete or misleading facts or information on this enrollment form for the purpose of defrauding or attempting to defraud the BAC IHF with regards to the application for benefits or claim for benefits. Penalties may include, but are not limited to, denial of benefits and repayment of moneys fraudulently paid on behalf of ineligible dependents.

**DEPENDENTS TO BE COVERAGE**

**ALL NEWLY ELIGIBLE PARTICIPANTS MUST SHOW PROOF OF DEPENDENT COVERAGE. EXAMPLES: BIRTH CERTIFICATE, MARRIAGE CERTIFICATE, OR AFFIDAVIT OF COMMON LAW MARRIAGE IN COMMON LAW MARRIAGE STATES. FORMS WILL NOT BE PROCESSESED IF PROOF OF DEPENDENT COVERAGE IS NOT ATTACHED.**

**TYPE OF COVERAGE DESIRED :**

Employee Only       Employee + 1 Dependent       Employee + Family

**DEPENDENTS TO BE COVERED**

DEPENDENT NAME	SOCIAL SECURITY NUMBER MANDATED	SEX M / F	DATE OF BIRTH	SPOUSE MEDICARE	
Spouse				<input type="checkbox"/> "A" <input type="checkbox"/> "B"	
Child				STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
Child				STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
Child				STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	

**DO YOU HAVE OTHER INSURANCE INFORMATION?**

**IF THIS ENROLLMENT FORM IS NOT COMPLETE, YOU WILL NOT BE ENROLLED IN THE PLAN.**

MEDICAL Names of those covered	Name/Address of Insurance Company	Effective Date/Policy Number	
DENTAL Names of those covered	Name/Address of Insurance Company	Effective Date/Policy Number	

SIGNATURE OF MEMBER \_\_\_\_\_

DATE \_\_\_\_\_

**BRICKLAYERS and ALLIED CRAFTWORKERS  
HEALTH PLAN**

**AUTHORIZATION TO RELEASE INFORMATION**

I request and authorize any physician, hospital, clinic, insurance company, employer, or other person or organization to furnish to the BAC Health Management Unit (HMU) authorized representative, and permit the HMU representative to obtain a statement or make or obtain, a copy, in whole or in part, of any or all information with respect to any illness or injury including medical history, diagnoses, consultation report, examination report, prescriptions, treatment plans, operative reports, x-rays, pathological findings and all psychiatric and psychological information or tests you may have concerning me or any eligible dependents on my policy.

I authorize you or the representative, on my behalf and any eligible dependents, to submit such information or statement or copy directly to the HMU to become a part of my claim.

This authorization is in effect as long as my eligible dependents and I have coverage through the HMU. A photocopy of this authorization shall be considered as effective and valid as the original.

Member's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Signature: \_\_\_\_\_

Spouse's Signature \_\_\_\_\_

Date: \_\_\_\_\_