

## BAC INTERNATIONAL HEALTH FUND HEALTH & WELFARE ENROLLMENT FORM

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

(Do not write in shaded area)

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

**CHANGE EFFECTIVE DATE:** \_\_\_\_\_ **LOCAL / LOCATION :** \_\_\_\_\_

Medical Group Number: 195858 Dental Group Number: 516220 Vision Group Number: 02109592

**MEMBER'S LAST NAME** \_\_\_\_\_ **FIRST NAME** \_\_\_\_\_ **MIDDLE INITIAL** \_\_\_\_\_ **DATE OF BIRTH :** MO \_\_\_\_\_ DAY \_\_\_\_\_ YEAR \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP CODE** \_\_\_\_\_ **TELEPHONE** \_\_\_\_\_

**DATE OF UNION MEMBERSHIP** \_\_\_\_\_ **SOCIAL SECURITY NUMBER** \_\_\_\_\_ **I.U. NUMBER** \_\_\_\_\_  MALE  FEMALE

**OTHER INSURANCE COVERAGE** \_\_\_\_\_ **IF MEDICARE ELIGIBLE** \_\_\_\_\_ **MARITAL STATUS** \_\_\_\_\_  
 YES  NO  "A"  "B" \_\_\_\_\_  
 \_\_\_\_\_ Single  
 \_\_\_\_\_ Married  
 \_\_\_\_\_ Divorced  
 \_\_\_\_\_ Widowed

**MEMBER STATUS:**  Active  Retired  Medicare  COBRA  Non-Job Site **STATUS CHANGE:** From \_\_\_\_\_ to \_\_\_\_\_ Date: \_\_\_\_\_

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** \_\_\_\_\_

**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 PROCESSED 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	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

**OTHER INSURANCE INFORMATION**

**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: \_\_\_\_\_