PLUMBERS AND STEAMFITTERS LOCAL 141 HEALTH AND WELFARE FUND
ENROLLMENT AND VERIFICATION FORM FOR ELIGIBILITY

7113 WEST BERT KOUNS IND LOOP
SHREVEPORT, LOUISIANA 71129
TELEPHONE: 318-688-6990

PLEASE PRINT ALL INFORMATION

LAST NAME	FIRST NAME IN FULL	MIDDLE NAME IN FULL

HOME ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	E-MAIL

SOCIAL SECURITY NUMBER	LOCAL UNION NO.	MALE/ FEMALE	DATE OF BIRTH	MARRIED/SINGLE DIVORCED/WIDOWED

ENROLLMENT AND VERIFICATION OF DEPENDENT ELIGIBILITY

DEPENDENT'S FULL NAME	SOCIAL SECURITY NUMBER	GENDER	DEPENDENT RELATIONSHIP	DATE OF BIRTH		
				MONTH	DAY	YEAR

_____ My spouse/dependents do not have group insurance.

_____ My spouse/dependents have other group insurance.

If your spouse or dependents have medical insurance through a group health plan, please indicate below:

Insured's name:_____

Insurance Company:_____

Insurance Company Address: _____

_____

Group #:_____ Policy #:_____

Effective Date of Coverage:_____

Please list the dependents covered by this policy:

_____

_____

_____

_____

_____

Coverage Type : _____ Medical only

_____ Medical & Dental

SIGNATURE: **DATE:**

_____

FOR FUND OFFICE USE ONLY:	FOR FUND OFFICE USE ONLY:
DATE RECEIVED BY FUND OFFICE:	DATE OF ENROLLMENT: _____
_____	EFFECTIVE DATE OF ELIGIBLITY: _____