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INDIANA LABORERS WELFARE FUND
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DEPENDENT ENROLLMENT FORM

Participant Name: _____ ID#:_____

I request the following dependent(s) be included in my health benefit plan coverage through the Indiana Laborers Welfare Fund. *Dependent(s) listed below are in addition to those already covered.*

Name of Dependent	Social Security Number	Date of Birth	Gender	Relationship to Participant

Are any of the above listed Dependents covered by any other medical/dental/prescription or vision plan?

☐ Yes ☐ No **If you answered "Yes," you must submit a copy of the front and back of all other benefit cards.**

The following information is **required** to be submitted with this form:

Spouse: copy of official certified marriage license or certificate of marriage signed by clerk or judge with official seal and a new beneficiary designation form (please request this form if not already in your possession).

Child: copy of the birth certificate, paternity papers (if member is not listed on the birth certificate), adoption order, and divorce decree or legal separation, including any settlement agreement (if parents are divorced). If parents are not divorced, you must submit any court documents pertaining to health coverage.

Step-child: copy of the birth certificate, copy of official certified marriage license or certificate of marriage signed by clerk or judge with official seal , and natural parent's divorce decree or legal separation including any settlement agreement (if natural parents are divorced). If natural parents were never married, you must submit any court documents pertaining to health coverage.

If you are enrolling your child or step-child and have not included a divorce decree, legal separation (including any settlement agreement), or any other court documents pertaining to health coverage with this form, you must indicate the reason why using the lines below:

_____

_____

_____ _____

Participant Signature Date