IBEW Local 613 and Contributing Employers
Family Health Fund

c/o National Employee Benefits Administrators, Inc.
3715 Northside Parkway Suite 2-495 ● Atlanta, GA 30327
2010 N.W. 150th Avenue, Suite 100 ● Pembroke Pines, FL 33028
1.800.922.1613 ● Fax 678.705.0205

1. First, tell us about yourself.

First Name		**Middle Initial**		**Last Name**	
Gender	☐ Male ☐ Female	**Birthdate**		**SS#**	
Address					
City		**State**		**Zip**	
Email Address					
Phone Number		**Alternate Number**			

2. Spouse Information *Complete only if electing coverage for your spouse. Legal spouses are covered with proof of a marriage certificate and Social Security Card. You are responsible to notify the Fund Office within 60 days if you get divorced.*

Spouse Name		**Middle Initial**		**Last Name**	
Gender	☐ Male ☐ Female	**Birthdate**		**SS#**	
Email Address					
Phone Number		**Alternate Number**			
Is this Spouse actively employed? (If "Yes," please have the Employer-Sponsored Health Coverage Verification Form completed by your spouse's employer)	☐ Yes ☐ No				

3. Dependent Children Information. *Complete for those children for whom you are electing coverage. Your natural or legally adopted children can be covered by the Family Health Plan. The courts may also place a child under your plan as a dependent by court order. Your dependent children will be added upon receipt of supporting documentation which includes: Birth Certificate and Social Security Card.*

	Dependent Child Full Name	Relationship	Birth Date	SSN	Gender
# 1					
Address, City, ST, Zip					
# 2					
Address, City, ST, Zip					
# 3					
Address, City, ST, Zip					
# 4					
Address, City, ST, Zip					

5. Signature. *I hereby certify that the information provided in this form, to the best of my knowledge and belief, is true, correct and complete, I understand that any false statements in this form may affect my and/or my dependent's continued eligibility for benefits under the Family Health Plan. I further understand that completion of this form does not guarantee eligibility for benefits.*

Participant Signature	*Date*

Opportunities for Special Enrollment

If you are declining enrollment for your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll your dependents in this plan if your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your dependents' other coverage). However, you must request enrollment within **30-days** after your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents. However, you must request enrollment within **30-days** after the marriage, birth, adoption, or placement for adoption.

If you have declined coverage for a dependent because that dependent was covered under Medicaid or the State Children's Health Insurance Program ("SCHIP"), you may be able to enroll your dependents in this plan if your dependent is no longer eligible for Medicaid or SCHIP. You may also be able to enroll your dependents in this plan if a dependent becomes eligible for premium assistance under Medicaid or SCHIP. However, you must request enrollment within **60-days** of the loss of eligibility for Medicaid or SCHIP or the date the dependent became eligible for premium assistance.

To request special enrollment or obtain more information, contact the Fund Office at (800) 922-1613.