MUST RETURN COMPLETED FORMS TO ACTIVATE INSURANCE

Iowa Laborer's District Council H/W Plan

3925 Fountains Blvd NE Ste 104 Cedar Rapids, IA 52411
Phone: 319/365/2810 Fax: 319/365/1043 – Toll Free (866) 365/2810

Benefit Information Sheet

This form must be completed fully. Please print clearly or type the information requested.

Member Name: _____ **Birth date:** _____
Participant's complete name including middle initial

Social Security #:_____**Male/Female** **Local/Employer:** _____

Street Address: _____

City, State, Zip Code:_____

Home phone #:_____**Cell Phone #**_____

Email Address _____

Please list dependents below (only if you have family coverage)

Name (Last,First,M.I.)	DOB (M/D/Year)	Sex (M/F)	Social Security Number

Spouse: _____

Child: _____

Child: _____

Child: _____

Child: _____

Child: _____

- **NOTE -** ***Enclose a copy of the state birth certificate and social security card for each child listed.*** **If the last name is different from yours, please explain their relationship to you.**
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Spouse's Insurance Co._____ **Policy #:**_____

Spouse's effective date of other insurance coverage:_____

Date of Marriage:_____***Enclose a copy of your Certificate of Marriage.***

Member's signature: _____ **Date:**_____

Please return completed form to the address listed above.