MUST RETURN COMPLETED FORMS TO ACTIVATE INSURANCE

Iowa Laborer's District Council H/W Plan

150 1st Ave NE Ste 450 Cedar Rapids, IA 52401
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/FemaleLocal/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.

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.