77 Huyshope Avenue, 2nd Floor
Hartford, CT 06106-7001
860/728-1100 Fax 860/947-8080

ENROLLMENT FORM

Planilla de registro

YOU MUST ANSWER ALL QUESTIONS AND PRINT CLEARLY IN INK

Debe Contestare las preguntas claramente en tinta y con letra de molde

(THIS FORM IS STRICTLY CONFIDENTIAL)

(Esta Planilla es estricturmente confidencial)

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1. PARTICIPANT INFORMATION (*Informacion de identificacion del Participante). Complete all the information and mark the right square that applies (Completar toda la informacion y Marca el cuadrado apropiado que coresponda)*

Attach copy of Birth Certificate *Incluya una copia de su certificado de Nacimiento*

<table>
<tr><td colspan="3">Participant Name (Last, First, Middle Initial): Nombre del Participante</td><td colspan="2">Social Security #: de Seguro Social</td></tr>
<tr><td colspan="2">Current Street Address: Domicilio</td><td>City: Ciudad</td><td>State: Estado</td><td>Zip: Zona Postal</td></tr>
<tr><td>Telephone: Area y No. de telefono
(   )
Home de casa ☐ Cell celular ☐</td><td>Date of Birth:
Fecha de Nacimiento</td><td>Sex: Sexo</td><td colspan="2">Marital Status: Estado Civil
Single ☐ Married ☐ Separated ☐
Divorced ☐ Widow ☐</td></tr>
<tr><td colspan="5">Email Address: direccion de correo electronico</td></tr>
</table>

2. EMPLOYMENT INFORMATION *Escriba la informacion de su empleo*

<table>
<tr><td colspan="3">Name of Employer Lugar de trabajo actual</td><td colspan="2">Work Telephone Trabajo Telefono
(   )</td></tr>
<tr><td colspan="2">Employer Street Address Direccion</td><td>City Ciudad</td><td>State
Estado</td><td>Zip Zona Postal</td></tr>
<tr><td>Date of Hire:
Fecha de Empleo</td><td colspan="2">Hours Per Week on hire date:
Horas por semana dia de contrato
Hourly Rate: $
Porcentaje por hora</td><td colspan="2">Your Position:
Posicion Laboral</td></tr>
<tr><td colspan="5">If you currently work for a second 1199 Employer list the second 1199 employer below.
Si tiene un Segundo trabajo con la 1199 nombre el otro lugar donde trabaja</td></tr>
<tr><td colspan="2">Employer Street Address Direccion</td><td>City Ciudad</td><td>State
Estado</td><td>Zip Zona Postal</td></tr>
<tr><td>Date of Hire:
Fecha de Empleo</td><td colspan="2">Hours Per Week:
Horas por semana dia de contrato
Hourly Rate: $
Porcentaje por hora</td><td colspan="2">Your Position:
Posicion Laboral</td></tr>
</table>

3. ADD SPOUSE Agregar al Esposo(a) *Complete all the information and mark the right square that applies (Completar toda la informacion y Marca el cuadrado apropiado que coresponda)* **Attach copy of Marriage License** *Incluya una copia de su certificado de Matrimonio* **and Birth Certificate** *certificado de Nacimiento*

Spouse's Name: (Last, First, Middle Initial) *Nombre completo del esposo(a)*		Social Security #: *Seguro Social del esposo(a)*	
Current Street Address: *Domicilio*	City: *Ciudad*	State: *Estado*	Zip: *Zona Postal*

Telephone: *Area y No. de telefono ( )* Home *de casa* ☐ Cell *celular* ☐	Date of Birth: *Fecha de Nacimiento*	Sex: *Sexo*

4. SPOUSE EMPLOYMENT INFORMATION *Escriba la informacion de su empleador*

Name of Employer: *Lugar de trabajo actual*		Work Telephone: *Telefono del trabajo* ( )	
Employer Street Address: *Direccion de su empleador*	City: *Ciudad*	State: *Estado*	Zip: *Zona Postal*

5. DEPENDENT CHILD(REN) INFORMATION ***Informacion de Hijos(as).*** *Complete all the information and mark the right square that applies (Completar toda la informacion y Marca el cuadrado apropiado que coresponda).* Eligible dependent children are covered to age 26, Physically and/or developmentally disabled children, age 26 or older, may be eligible for additional coverage. Call the Fund Office for information. ***If you need to add additional children complete the Additional Dependents form provided in this packet.***

1st Child's Name: (Last, First, Middle Initial) *Nombre Completo*	Social Security #: *No. de Seguro Social*	Son/Daughter: *Parentesco*	Date of Birth: *Fecha de nacimiento*
Street Address: *Domicilio*	City: *Ciudad*	State: Estado	Zip *Zona Postal*
2nd Child's Name: (Last, First, Middle Initial) *Nombre Completo*	Social Security #: *No. de Seguro Social*	Son/Daughter: *Parentesco*	Date of Birth: *Fecha de nacimiento*
Street Address: *Domicilio*	City: *Ciudad*	State: Estado	Zip: *Zona Postal*

3rd Child's Name: (Last, First, Middle Initial) *Nombre Completo*	Social Security #: *No. de Seguro Social*	Son/Daughter: *Parentesco*	Date of Birth: *Fecha de nacimiento*
Street Address: *Domicilio*	City: *Ciudad*	State: Estado	Zip: *Zona Postal*

6. BENEFICIARY INFORMATION- DEATH BENEFIT Informacion del *Beneficiario.* **List name and address of person(s) to whom your Death Benefit is to be paid. State how the person(s) are related to you (You cannot name yourself as a beneficiary). If a minor, state age, and give name of parents or guardian in "Remarks". If more than one person is to share the Death Benefit, indicate the percentage or share each is to receive in "Remarks".** Indique nombre y direcion de la persona(s) que debe recibir el Beneficio. Indique el parentesco con la person(s). Si la persona es menor de edad senale la edad y el nombre de los padres o de la personal reponsable del menor en "Notas". Si mas de una persona va a compartir el Beneficio de Defuncion indique en "Notas" el percentage or parte que cada persona debe recibir.

PRIMARY Beneficiary Name: (Last, First, Middle Initial) *Nombre del Beneficiario Primario*	Relationship to You: *Parentesco con el Participante*	Birth Date: *Fecha de nacimiento*
Street Address: *Domicilio del Beneficiario(os) Primario*	City: *Ciudad* State: *Estado*	Zip: *Zona Postal*

If the PRIMARY beneficiary is deceased at the time of your death, list the name and address of the SECONDARY person(s) to whom your Death Benefit is to be paid. State how the person(s) are related to you (You cannot name yourself as a beneficiary). If a minor, state age, and give name of parents or guardian(s) in "Remarks". If more than one person is to share the Death Benefit, indicate the percentage or share each is to receive in "Remarks". *Si el beneficiario primario ha fallecido al tiempo de su muerte, indique nombre y direccion de la Segunda persona(s) que debe recibir el Beneficio de Defuncion. Indique el parentesco con la person(s). Si la persona es menor de edad senale la edad y el nombre de los padres o de la persona responsable del menor en "Notas". Si mas de una persona va a compartir el Beneficio de Defuncion indique en "Notas" el percentage or parte que cada una debe recibir.*

SECONDARY Beneficiary Name: (Last, First, Middle Initial) *Nombre del Beneficiario Secundario*	Relationship to You: *Parentesco con el Participante*	Birth Date: *Fecha de nacimiento*
Street Address: *Domicilio del Beneficiario(ios) Primario*	City: *Ciudad* State: *Estado*	Zip: *Zona Postal*
REMARKS: (Other Beneficiary) *Notas de los Beneficiarios*		

THE FORGOING STATEMENTS ARE TO THE BEST OF MY KNOWLEDGE TRUE AND COMPLETE. *La declaracion anterior es totalmente cierta y es hecha en pleno ejercicio de mis facultades fisicas y mentales.*

X________________________________ ________________________________

Participant Signature *Firma del Participante* Date: *Fecha*

THIS INFORMATION MAY BE USED FOR PURPOSES OF UPDATNG THE FUND'S RECORDS
Esta informacion podrd usarse con el fin de poner al dia mi expediente personl

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New England Health Care Employees
WELFARE FUND

77 Huyshope Avenue, 2nd Floor
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860/728-1100 Fax 860/947-8080

COORDINATION OF BENEFITS (COB)

SECTION 1: PARTICIPANT INFORMATION

Participant Name: Last Name, First Name	**Birth Date:**	**Employment Status** Active ☐ Retired ☐	**If Retired**, Date of Retirement
Member ID or Social Security #		**Home/Cell Phone Number**:	

SECTION 2: OTHER HEALTH INSURANCE INFORMATION

Name of Policy Holder of other insurance: Last Name: First Name:	**Birth Date:**	**Sex:** Male ☐ Female ☐	**Social Security #**	**Relationship to You** (If not self)

Name of Other Health Insurance Company:	**Policyholder Identification Number:**
Other Health Insurance Company Address:	**Other Health Insurance Company Phone #**

List Family Member(s) with coverage including birth date of each and effective date of coverage(if more space is needed, please list additional members and relationship to you on the back of this form:

Coverage Type:

Group ☐ **Medical** ☐ Dental ☐ **Vision** ☐ **Drug** ☐

Coverage Effective Date:___________________**Coverage Cancellation Date(If Applicable)**:________________________

SECTION 3: MEDICARE COVERAGE INFORMATION

Name of Medicare Participant: Last Name: ____________________________**First Name:**___________________

Effective Date Part D:______________________

Medicare Eligibility Due to:

Age ☐ **Disability** ☐ **End-Stage Renal Disease** ☐ **Initial Dialysis Date**:___________________

SECTION 4: SIGNATURE AND DATE

I certify that the information furnished by me on this form is true and correct at this time and agree to inform the 1199 New England Health Care Employees Welfare Fund ("The Fund") of any changes.

Participant Signature: **Today's Date:**

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Spouse's Employer
No Health Coverage Verification

Participant Name: ______________________________Date of Birth:______________________

Spouse's Name: ______________________________Spouse's Date of Birth: ____________

Spouse's Employer Name:

____

Spouse's Employer's
Address:____
Street Name City State Zip Code

Spouse's Employer's Telephone Number:____

I certify that ______________________________________does **not** ***offer*** Health Insurance to:
Name of Spouse's Employer

____
Spouse's (Employee) Name

____
Employer Representative's Name (Print)

____
Employer Representative Signature

____
Employer Representative Title

____
Spouse's Signature

____
Date

____
Participant's Signature

____
Date

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SPOUSE AFFIDAVIT EMPLOYMENT VERIFICATION

I, ________________________________, being duly sworn, hereby depose and say:

1. ☐ I am **NOT** employed *(check this box)* **(attach a copy of your most current Tax Returns)**

Or

2. ☐ I am self-employed *(check this box)*

I understand that the Welfare Fund will rely on the accuracy and truthfulness of this affidavit, and I agree to reimburse the Welfare Fund for any benefits paid as the result of any inaccuracy or misstatement in this affidavit.

_________________________ ____
Spouse Name (Print) Spouse Address if different from participant

___________________________ ____
Spouse Signature Date

NOTARY:

STATE OF CONNECTICUT

COUNTY OF ____________________________

Personally appeared ______________________ and made oath to the truth of the matter contained in the foregoing Affidavit before me this___day of _____________.

____

Notary Public

My Commission expires:

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If you need to add additional dependents, you can add them below:

4th Child's Name: (Last, First, Middle Initial) *Nombre Completo*	Social Security #: *No. de Seguro Social*	Son/Daughter: *Parentesco*	Date of Birth: *Fecha de nacimiento*
Street Address: *Domicilio*	City: *Ciudad*	State: Estado	Zip: *Zona Postal*

5th Child's Name: (Last, First, Middle Initial) *Nombre Completo*	Social Security#: *No. de Seguro Social*	Son/Daughter: *Parentesco*	Date of Birth: *Fecha de nacimiento*
Street Address: *Domicilio*	City: *Ciudad*	State: Estado	Zip: *Zona Postal*

6th Child's Name: (Last, First, Middle Initial) *Nombre Completo*	Social Security#: *No. de Seguro Social*	Son/Daughter: *Parentesco*	Date of Birth: *Fecha de nacimiento*
Street Address: *Domicilio*	City: *Ciudad*	State: Estado	Zip: *Zona Postal*

7th Child's Name: (Last, First, Middle Initial) *Nombre Completo*	Social Security#: *No. de Seguro Social*	Son/Daughter: *Parentesco*	Date of Birth: *Fecha de nacimiento*
Street Address: *Domicilio*	City: *Ciudad*	State: Estado	Zip: *Zona Postal*

8th Child's Name: (Last, First, Middle Initial) *Nombre Completo*	Social Security#: *No. de Seguro Social*	Son/Daughter: *Parentesco*	Date of Birth: *Fecha de nacimiento*
Street Address: *Domicilio*	City: *Ciudad*	State: Estado	Zip: *Zona Postal*

9th Child's Name: (Last, First, Middle Initial) *Nombre Completo*	Social Security#: *No. de Seguro Social*	Son/Daughter: *Parentesco*	Date of Birth: *Fecha de nacimiento*
Street Address: *Domicilio*	City: *Ciudad*	State: Estado	Zip: *Zona Postal*

10th Child's Name: (Last, First, Middle Initial) *Nombre Completo*	Social Security#: *No. de Seguro Social*	Son/Daughter: *Parentesco*	Date of Birth: *Fecha de nacimiento*
Street Address: *Domicilio*	City: *Ciudad*	State: Estado	Zip: *Zona Postal*