# UA Local 190
# Health and Welfare Plan
# Member Application

## A. Coverage Information

| Health Coverage: ☐ Yes ☐ No | If YES please check one coverage type: ☐ Employee Only ☐ Emp. & One ☐ Emp. & Two or more |
|---|---|

## B. Applicant and Family Information

| Name: Last First Middle | Are you: ☐ Single ☐ Married ☐ Sep. ☐ Div. ☐ Widowed | Home Phone number: ( ) |
|---|---|---|
| Address: Street City State Zip | | County |

Please complete below for each eligible family member you want covered, including yourself. (Your spouse and any eligible dependents.) Attach a second sheet, if necessary.

**Important:** In last column, check "yes" **only** if other group health insurance will remain in effect.

| First Name Middle Last (if different) | Sex M/F | Relationship to Applicant * | Date of Birth Mo Day Yr | Social Security Number | Totally Disabled | Enrolled in Medicare | Enrolled in other Group Coverage |
|---|---|---|---|---|---|---|---|
| 00 Applicant | | **SELF** | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 01 Spouse | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 02 Child | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 03 Child | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 04 Child | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 05 Child | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 06 Child | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

***** If stepchild please complete Part C on Page 2

**Medicare Information:** If you or any dependents checked YES to being enrolled in Medicare, please give the following Medicare

| Name | Medicare No. | Part A / Part B eff. Date | Reason for Medicare Eligibility |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |



Application continued on reverse side

**Disability Information:** If you or any dependents checked YES to being Totally Disabled, please give the following information:

| Name | Describe Disability |
|---|---|
| | |
| | |
| | |

## C. Stepchildren

**If you have listed a step child as a dependent for insurance eligibility purposes, please answer the following questions, and attach copies of adoption/guardian papers or court order.**

1. What percentage of the child's annual support do you contribute? _____ %
2. Does the child live in your home full time? ☐ Yes ☐ No
3. Do you claim the child on your federal income tax return as a dependent? ☐ Yes ☐ No

## D. Health

Have you, your spouse, or dependent during the last five years;

1. Consulted, been examined or treated by a physician or practitioner? ☐ Yes ☐ No

| Name | Reason | Date of Service | Physicians Name & Address, PA# |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

2. Had a X-ray, electrocardiogram or lab tests? ☐ Yes ☐ No

| Name | Reason | Date of Service | Physicians Name & Address, PA# |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

3. Used cocaine, heroin, morphine, LSD, marijuana, PCP, or any other hallucinogenic or narcotic drug? ☐ Yes ☐ No

## E. Certification

**I certify that the above information contained in this application is correct to the best of my knowledge and belief.**

**X** _____ **X** _____

Applicants Signature Date