

# Participant Data Card

## Electrical Workers Benefit Trust Fund

Please PRINT. This form must be completed, signed, and returned to the Fund Office prior to payment of claims.

### Part A - Participant Information

1 Participant Name: \_\_\_\_\_ 2 Phone: \_\_\_\_\_  
Last First Initial

3 Participant Address: \_\_\_\_\_ 4 Date of Birth: \_\_\_\_\_ 5 Social Security #: \_\_\_\_\_ 6 Classification \_\_\_\_\_  
Street Address City State Zip Code  
Month Day Year

7 Status (circle one):    Single    Married    Legally Separated    Divorced    Widowed    8 Date of Status: \_\_\_\_\_  
Month Day Year

### Part B - Dependent Information

Name of Dependents (including Spouse)	Date of Birth Mo/Day/Year	Social Security #	Relationship

\* When adding or removing dependents, a copy of the Birth Certificate, Marriage Certificate or Divorce Decree must be provided.

### Part C - HIPAA Authorization

This section authorizes the Fund Office to release Private Health Information (PHI) to other family members. PHI includes but is not limited to medical history, diagnosis or treatment and the names of treating physicians.

The following adult family members (age 18 or older, including spouse) authorize the Fund Office to share all medical information with other adult family members (age 18 or older), unless a limitation is noted:

Name of Family Member (Print)	Signature of Family Member	Relationship to Participant	Date Signed	Limit Sharing to:

### Part D - Beneficiary Designation

Name of Beneficiary: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Street Address City State Zip Code

**NOTE:** If you are married and you designate someone other than your legal spouse as beneficiary, Federal law requires your spouse's written consent. Forms for this purpose are available at the Fund Office.

### Part E - Authorization

**I hereby enroll in the Electrical Workers Benefit Trust Fund, IBEW Local Union #481, issued by the Board of Trustees.** I authorize any physician, hospital, employer, union, insurance company, or prepayment organization to furnish the Electrical Workers Benefit Trust Fund any additional information required in connection with my claim.

\_\_\_\_\_  
*Participant's Signature* \_\_\_\_\_ *Date*

