SEIU LOCAL 32BJ, DISTRICT 36 BUILDING OPERATORS WELFARE FUND

Please complete the information requested on both sides of this form to add your dependent to the Plan. Please attach a copy of your marriage license (for spouse) or birth certificate naming both parents (for child/children). If adding an adopted child or children, please supply adoption documentation.

Participant's Name	Participant's Social Security Number

Add dependent spouse child or children						
1. Last Name	First Name	Social Security #	Relationship to Participant	Date of Birth	Primary Care Physician Name	Primary Care Physician ID #
Street Address	Apartment #	City	State	Zip Code	Telephone #	Date of Birth
2. Last Name	First Name	Social Security #	Relationship to Participant	Date of Birth	Primary Care Physician Name	Primary Care Physician ID #
Street Address	Apartment #	City	State	Zip Code	Telephone #	Date of Birth
3. Last Name	First Name	Social Security #	Relationship to Participant	Date of Birth	Primary Care Physician Name	Primary Care Physician ID #
Street Address	Apartment #	City	State	Zip Code	Telephone #	Date of Birth

Side 1 (Turn over and complete the other side of this form)

For each dependent you have named, please let us know whether that dependent has coverage under another group health plan beside your group health plan through the SEIU Local 32 BJ, District 36 Building Operators Welfare Fund. **Print** yes or no in Column 2. If you wrote yes, please complete columns 3 through 7.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
Name of Covered dependent	Is this dependent covered under another group health plan	Name of Subscriber or Policyholder	Relationship to Subscriber/Policyholder	Name of Carrier or Health Plan	Group Number	Subscriber or Policyholder ID #

I certify that the information on both sides of this form is correct and acknowledge that if I, the Fund participant or my dependents willfully misuse or misrepresent any information about eligibility for any other group health coverage provided either through the course of their own employment or coverage provided from another source (i.e. parent, step-parent, or spouse's health coverage), the Fund has the right to terminate benefits for myself and my dependents. Furthermore, should my dependents acquire group health coverage through their own employment, that of a spouse, parent or step-parent, I will immediately notify the Fund Office.

_____ _____

Signature Date