UA

PLUMBERS & PIPEFITTERS LOCAL UNION 344
HEALTH & WELFARE FUND
4337 S W 44 Street
Oklahoma City, OK 73119-2857
405-682-4581
PREVENT DELAYS - ANSWER ALL QUESTIONS

This form must be completed and signed by the member before any claims will be processed. All questions must be answered. ***Remember if you are adding dependents, include copies of Birth Certificates and Social Security Cards***

SECTION ONE - MEMBER INFORMATION			Please check if this is a change of address
Name	Mailing Address	City, State, Zip Code	
Date of Birth	Social Security Number	Home Phone	Local Union # 344
Are you covered under any other Dental, Vision, or Group Health Plan? ☐ Yes ☐ No • Check all that apply ☐ Dental ☐ Vision ☐ Medical ☐ Prescription If Yes, You must complete section 3 (Insurance Information)			Medicare: ☐ Yes ☐ No

SECTION TWO - SPOUSE INFORMATION		
Spouse Name	Date of Birth	Social Security Number
Spouse Address		

Sex ☐ Male ☐ Female	Name & Address of Employer	Is spouse covered under any other Dental, Vision or Health Plan? ☐ Yes ☐ No * Check all that apply ☐ Dental ☐ Vision ☐ Medical ☐ Prescription If Yes, You must complete section 3 (Insurance Information)

SECTION THREE - OTHER INSURANCE INFORMATION	
Name of Insured	Insured's ID Number
Policy or Plan No.	Type of Coverage ☐ Individual ☐ Family
Name, Address and Phone No. of Insurance Co.	

List all family members who are covered on this plan.

_____ _____
_____ _____
_____ _____

I certify that all information is true and correct. I authorize the release of any and all medical records to the administrative management for the purpose of determining my benefits payable under the provisions of this plan and any other plan.

DATE	MEMBER'S SIGNATURE

PLEASE LIST ADDITIONAL DEPENDENTS ON BACK

Dependent Name	Date of Birth	Social Security No

Dependent's Address

Relation to Member ☐ Child ☐ Step Child	Sex ☐ Male ☐ Female	Is dependent covered under any other Dental, Vision, or Health Plan? ☐ Yes ☐ No * Check all that apply ☐ Dental ☐ Vision ☐ Medical ☐ Prescription
Child living with you? ☐ Yes ☐ No Child under the age of 26? ☐ Yes ☐ No		If Yes, You must complete the following: Name of Insured _____ Group or Plan Number _____ Insured's ID No _____ Type of coverage ☐ Family ☐ Individual Name, address & phone number of Insurance Co.

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Dependent's Address

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