



Return this form by mail, fax or email:
SMART Local 36
Health and Welfare Fund - MO Plan B
2319 Chouteau Ave., Ste. 300
St. Louis, MO 63103
Phone: 314-652-8175
Fax: 314-652-9356
email: mhagemann@sheetmetal36.org

Participant's Name: _____ Participant's Social Security No: _____
 Address: _____ Birthdate: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone Number: _____ Cell Phone: _____ Email: _____
 Spouse cell phone: _____ Spouse Email: _____

Are you retired and eligible for Medicare benefits? Yourself YES NO Spouse YES NO

If yes, please provide effective date for Medicare coverage for yourself and/or your spouse.

Member Medicare Number: _____ Spouse Medicare Number: _____
 Member Medicare PART A Effective: __/__/____ Spouse Medicare PART A Effective: __/__/____
 Member Medicare PART B Effective: __/__/____ Spouse Medicare PART B Effective: __/__/____

Dependents Covered Under SMW Local 36 Benefit Fund

NAME	RELATIONSHIP	DOB	SSN	DOES DEPENDENT LIVE WITH YOU	OTHER COVERAGE
	Self/Member			YES NO	YES NO
	Spouse			YES NO	YES NO
				YES NO	YES NO
				YES NO	YES NO
				YES NO	YES NO
				YES NO	YES NO
				YES NO	YES NO

******Please complete the following for each additional plan covering you or your dependents******

(This would include other insurance providing coverage through yourself, spouse, parents, or step-parents of dependent children)

Type of Coverage: Medical _____ Dental _____ Rx _____ Vision _____
 Name of Plan: _____ Effective Date: _____ Subscriber ID #: _____
 Plan Phone Number: _____
 Name of Subscriber: _____ Relationship to member: _____
 List dependents covered under this plan: _____

Type of Coverage: Medical _____ Dental _____ Rx _____ Vision _____
 Name of Plan: _____ Effective Date: _____ Subscriber ID #: _____
 Plan Phone Number: _____
 Name of Subscriber: _____ Relationship to member: _____
 List dependents covered under this plan: _____

Note (if applicable): If you haven't already submitted your divorce decree or court order please do so. This must be on file in order to determine benefit eligibility.

Birth certificate, SSN card copy and marriage certificate will be required for any NEW enrollment.

I understand that the SMART LOCAL 36 Health and Welfare Fund may receive information from any source and may use my personal health information and that of my eligible dependents for treatment purposes, for payment purposes, for its health care operations and for other reasons permitted under the Health Insurance Portability and Accountability Act, without specific authorization from me.

PARTICIPANT SIGNATURE: _____ DATE: _____

PLEASE COMPLETE REGARDING ADULT DEPENDENTS:

DEPENDENT CHILDREN AGES 19-26 YRS (REGARDLESS OF FULL TIME STUDENT STATUS)

Adult Dependent Child's Information

Last:		First:	Middle Int:
Home Address:		City:	State:
Zip Code:	Home Phone:	Cell phone:	
Are you currently employed?: YES NO		Are you currently married?: YES NO	
Do you have other insurance coverage available through your own employer or your spouse's employer?: YES NO			
Have you elected this coverage?: YES NO			

Type of Coverage: Medical _____ Dental _____ Rx _____ Vision _____
 Name of Plan: _____ Effective Date: _____
 Name of Subscriber: _____ Relationship: _____
 Phone Number: _____ Termination Date: _____

Adult Dependent Child's Information

Last:		First:	Middle Int:
Home Address:		City:	State:
Zip Code:	Home Phone:	Cell phone:	
Are you currently employed?: YES NO		Are you currently married?: YES NO	
Do you have other insurance coverage available through your own employer or your spouse's employer?: YES NO			
Have you elected this coverage?: YES NO			

Type of Coverage: Medical _____ Dental _____ Rx _____ Vision _____
 Name of Plan: _____ Effective Date: _____
 Name of Subscriber: _____ Relationship: _____
 Phone Number: _____ Termination Date: _____

Please submit copies of other insurance cards if applicable.