N.E.C.A.-I.B.E.W. LOCAL 480 ENROLLMENT FORM
P.O. BOX 721119 BYRAM, MS 39272

Please complete and return to the above address as soon as possible. Claims will be denied until this information and our files are updated.

Employee SSN	Employee Last Name	Employee First Name	MI

Home Phone No.	Street Address	City	ST		Zip

Gender		Date of Birth	Marital Status		Date of Marriage
( ) M	( ) F				

Do you have other health coverage	No Yes	If yes, Carrier Name and Address	Policy No. and Eff Date	Medicare ( ) A ( )B

Provide the following information for all person to be covered

Full Name	Gender	DOB	Indicate Yes or No for each item		Carrier (include Medicare
Relationship to Employee	M/F	MM/DD/YY	Full Time Student	Other Health Coverage	Employer (if Applicable)
Spouse		SSN			
1.Dependent/Relationship		SSN			
2.Dependent/Relationship		SSN			
3.Dependent/Relationship		SSN			
4.Dependent/Relationship		SSN			
5.Dependent/Relationship		SSN			
6.Dependent/Relationship		SSN			

DEPENDENT CHILD INFORMATION

Please complete the section below for any child not born of your current marriage. Send a copy of the natural parent's Divorce Decree, so it may be determined who has the responsibilty for the child's medical coverage.

Child's Name	Relationship
Child's Name	Relationship

If the Natural Mother is not covered by the NECA IBEW Local 480 Health & Welfare Fund, please complete the following

Natural Mother's Name	SSN
Natural Mother's Address	
Natural Mother's Employer's Name and Address	
Natural Mother's Insurance Co. Name and Address	

If the Natural Father is not covered by the NECA IBEW Local 480 Health & Welfare Fund, please complete the following	
Natural Father's's Name	SSN
Natural Father 's Address	
Natural Father's Employer's Name and Address	
Natural Father's Insurance Co. Name and Address	

Name of Parent with Custody of Child

For each child not born of your current marriage, please provide the answers to the above questions on a separate sheet of paper and attach to this form

For any child who is your natural child but is not born of a valid marriage and who does not reside with you, please submit a copy of the Court Decree relating to the responsibility for healthcare benefits.

Employee signature	Date

email_____