I.B.O.T.U Health and Welfare Fund – Enrollment Card

PRIMARY APPLICANT INFORMATION	
Benefit Plan Name:	**Coverage:** ☐ **Single** ☐ **E+S** ☐ **E+C** ☐ **Family**
Last Name:	**First Name:**
Height: **Weight:**	**Primary Care Physician (PCP):**
Home Address:	**Social Security:**
City/State/Zip Code:	**Date of Birth:**
Email:	**Home Phone:**
Gender: ☐**Male** ☐**Female**	**Marital Status:** ☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed**
Employer's Name:	**Business Phone:**
Hours Worked per week:	**Date of Employment:**
Is your Spouse Employed: ☐ **Yes** ☐ **No**	**If yes, where:**
Does your spouse have other coverage: ☐**Yes** ☐**No**	**If yes, Plan name & Policy #:**

SPOUSE / DEPENDENT INFORMATION BELOW* (*Spouse and unmarried children over 90 days old and under 19)*	
Dependent Name:	**Relationship:** **Height:** **Weight:**
SS#	**Date of Birth:**
Primary Care Physician (PCP):	**PCP Telephone #:** **Are you existing patient:** ☐Yes ☐No
Dependent Name:	**Relationship:** **Height:** **Weight:**
SS#	**Date of Birth:**
Primary Care Physician (PCP):	**PCP Telephone #:** **Are you existing patient:** ☐Yes ☐No
Dependent Name:	**Relationship:** **Height:** **Weight:**
SS#	**Date of Birth:**
Primary Care Physician (PCP):	**PCP Telephone #:** **Are you existing patient:** ☐Yes ☐No
Dependent Name:	**Relationship:** **Height:** **Weight:**
SS#	**Date of Birth:**
Primary Care Physician (PCP):	**PCP Telephone #:** **Are you existing patient:** ☐Yes ☐No
Dependent Name:	**Relationship:** **Height:** **Weight:**
SS#	**Date of Birth:**
Primary Care Physician (PCP):	**PCP Telephone #:** **Are you existing patient:** ☐Yes ☐No

FULL NAME OF BENEFICIARY BELOW	
***Primary:**	**Relationship:**
***Contingent:**	**Relationship:**

**The Group Policy reserves to the member a right to change his/her beneficiary*

I designate the beneficiary shown above to receive all sums which may become due on account of death under the group policy (ies) issued to the above named policyholder by I.B.O.T.U. Health & Welfare Fund and hereby request the insurance for which I may become eligible under said policy (ies).

In the past (5) year has any applicant seen a doctor, been diagnosed with, had treatment, hospitalization, medications, tests, or has been advised to have treatment or surgery for anything of the following	
a. *Heart attack, brain tumor, stroke, heart disease or heart problems?* ☐ YES ☐ NO	e. *Kidney failure, dialysis, or disorder of the liver, stomach, pancreas, colon or bladder?* ☐ YES ☐ NO
b. *Cancer, tumor, lymphoma, or any type of transplant?* ☐ YES ☐ NO	f. *Seizures, epilepsy, hemophilia, or blood disorder?* ☐ YES ☐ NO
c. *Any surgery or hospitalization currently pending, planned or recommended?* ☐ YES ☐ NO	g. *Diabetes, endocrine, or pituitary disorder, growth disorder, lupus, MS, AIDS, or HIV+?* ☐ YES ☐ NO
d. *Emphysema or COPD?* ☐ YES ☐ NO	h. *Currently pregnant, premature delivery, or multiple births? Pending due date* ☐ YES ☐ NO

If you answered YES to ANY of the above Health Questions, Please provide explanations in boxes below

Letter:	Applicant Name:	Condition/ Diagnosis:	Date of onset:	Date of recovery?	Current Treatment? ☐ YES ☐ NO	Taking Medication? ☐ YES ☐ NO
Treatment Given or needed?		Medication names:		Surgery or Hospitalization?		

Letter:	Applicant Name:	Condition/ Diagnosis:	Date of onset:	Date of recovery?	Current Treatment? ☐ YES ☐ NO	Taking Medication? ☐ YES ☐ NO
Treatment Given or needed?		Medication names:		Surgery or Hospitalization?		

Letter:	Applicant Name:	Condition/ Diagnosis:	Date of onset:	Date of recovery?	Current Treatment? ☐ YES ☐ NO	Taking Medication? ☐ YES ☐ NO
Treatment Given or needed?		Medication names:		Surgery or Hospitalization?		

APPLICATION*Authorization and Signature*

My signature declares that the answers and information presented on this application are complete and true for all Applicants to the best of my knowledge and belief, and this information will be used as the basis for underwriting. I understand that the answers in this application will not be used to determine whether I or my dependents, if applicable, are or are not eligible to participate in the IBOTU Health and Welfare Fund.
I further understand that the following parties may need to provide or collect information on me or my Dependents Applications. IBOTU and its reinsurers, any insurance support organization, related Business Associates, any consumer reporting agency, physicians, hospitals, clinics, and all persons authorized to represent those organizations for this purpose. I authorize any health care provider, hospital or medically related facility, pharmacy, or pharmacy related facility, consumer reporting agency, insurance or Reinsurance Company, having information about me or any of my Dependent Applications to provide all such information as requested by IBOTU or its Business Associates or Agents.

I understand that this Authorization may be needed for the purpose of gathering information to make eligibility, underwriting and group rating determinations and includes any and all information regarding diagnosis, treatment, and prognosis or medical conditions including physical, mental, psychiatric, drug, alcohol, and prescription history. Unless revoked earlier, this authorization will be valid for thirty (30) months after the date it is signed, and a photocopy of this authorization is as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to IBOTU.

Employee/Primary Printed Name: ______________________________________

Employee/Primary Signature: ____ Date: ____/____/_____