ELECTRICIANS HEALTH & WELFARE PLAN
IBEW 995 ("Plan")

8111 Tom Drive, Baton Rouge, LA 70815
(225)927-6340
Fax: (225)927-6344

2026 CLAIM FORM

"You" or "your" means an eligible employee. The purpose of this Claim Form is to provide updated information to the Plan for you and each of your enrolled dependents (spouse and children). You must complete this Claim Form when you are initially eligible for coverage and thereafter for each calendar year, and return it to the Plan before claims will be processed. NOTE: There is a separate Dependent Enrollment Form that is required if you want to enroll your dependents or make enrollment changes.

_____

Covered Employee's Name **Social Security No.** **Date of Birth**

_____ **No changes from 2025 (if no changes skip to signature at bottom of page)**

_____

Address **City, State, Zip Code** **Is Address New? Y N**

Phone Number _____

Marital Status: **Single** **Married** **Divorced** **Widowed**

If you are divorced, do you have custody of any child? **Y N** If yes, please list the name(s):_____

_____

Is there a court order requiring you to provide health insurance? **Y N**
If yes, name the person with the court order and supply a copy of the court order: _____

Other Insurance: If you or any covered family member has Medicare, Medicaid or other group health insurance or coverage, you must list (1) *the effective date and type of each coverage*, (2) *the persons who are covered*, and (3) *the name/address of any employer through which the other coverage is provided*:

_____

_____

_____

_____

Are YOU enrolled in Medicare PART D? Y N | Is your SPOUSE enrolled in Medicare PART D? Y N

SIGNATURES OF EMPLOYEE AND ENROLLED SPOUSE ARE REQUIRED. By signing below, I certify that the foregoing answers are true and correct to the best of my knowledge and to confirm that I must inform the Plan immediately of any changes to this information. Whoever knowingly makes any false statement or representation of fact or fails to disclose a required fact may be subject to fine or imprisonment.

_____ _____

Employee's Signature **Enrolled Spouse's Signature**

Print Name: _____ **Print Spouse's Name:** _____

Date Signed: _____ **Date Signed**: _____