IBEW Local 347 Electrical Workers
Health and Welfare Fund

PO Box 26068
Salt Lake City, UT 84126-0068

CompuSys of Utah, Inc.

Toll Free (844) 347-IBEW (4239)
Fax (801)973-1007

ENROLLMENT FORM

Directions: Complete this Enrollment Form and return it to the Fund Office. **You must submit the following items to the Fund Office with this Enrollment Form** (as applicable):

- If you or your Dependent(s) have other group medical coverage, you **must** include a photocopy of the front and back of the I.D. card for the other coverage.
- If you are married, you must include a copy of your Marriage Certificate.
- If you are enrolling a Dependent child(s), you must include a copy of the child's birth certificate, adoption papers, or court order for custody and support or maintenance (as applicable).

PARTICIPANT'S NAME (Last, First, Initial)	**GENDER** ☐ M ☐ F	**DATE OF BIRTH** (MO/DAY/YEAR)
PARTICIPANT'S MAILING ADDRESS: _____ Street _____ City State Zip **PHONE NUMBER:**	**MARITAL STATUS:** ☐ Single ☐ Married **If Married, Date of Marriage:** _____/_____/_____ ☐ **Divorced** ☐ **Widowed** **If Divorced, Give Date and Place of Final Decree** **Date of Divorce:** _____/_____/_____ **Place:** _____	
ARE YOU INSURED UNDER ANY OTHER GROUP, GOVERNMENT, EMPLOYER OR OTHER INSURANCE PLAN? **YES ☐ NO ☐**	**PARTICIPANT'S SOCIAL SECURITY NUMBER:**	

SPOUSE AND DEPENDENT CHILD INFORMATION: Make sure you fill out all of the information for each Dependent that is eligible for coverage from the Plan. If you have more than five eligible Dependents, attach a separate sheet of paper with information regarding those additional Dependents and list your name at the top of the sheet of paper.

Full Name (Last, First, M.I.)	**Social Security Number**	**Gender**	**Date of Birth** (Mo/Day/Year)	**Relationship to Participant**	**Other Insurance** (Must Circle Y or N)
					Y or N
					Y or N
					Y or N
					Y or N
					Y or N

The following is extremely important information. Please read this language carefully and then sign and date this Enrollment Form and return it to the Fund Office. If you are married, both you and your spouse must sign and date this Enrollment Form.

I hereby certify that all information provided on this Enrollment Form is correct to the best of my knowledge. I understand that if this information changes, it is my responsibility to notify the Fund Office immediately. I also understand that I will be required to reimburse the IBEW Local 347 Electrical Workers Health and Welfare Fund for any payments made as a result of my failure to notify the Fund Office of a change in the information provided on this Enrollment Form.

SIGNATURE OF PARTICIPANT _____ DATE _____

SIGNATURE OF SPOUSE _____ DATE _____