

# UNITED FURNITURE WORKERS INSURANCE FUND

1910 AIR LANE DRIVE - NASHVILLE, TENNESSEE 37210

## ENROLLMENT FORM (PLEASE PRINT CLEARLY)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Mid. Init. \_\_\_\_\_

Home Address/Telephone No. \_\_\_\_\_ E-mail address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender:  Male  Female

Marital/Relationship Status:  Single  Married  Divorced  Domestic Partnership

\*In the event that Enrollee is engaged in a Domestic Partnership, Enrollee must complete an Affirmation of Domestic Partnership form and any other forms required by the Fund.

Employer's Name \_\_\_\_\_ Local # \_\_\_\_\_

Date of Hire \_\_\_\_\_

**TYPE OF COVERAGE YOU ARE SELECTING:**

Single  Employee + Spouse/Domestic Partner  Employee + Child(ren)  Family

My Death Benefit (if applicable) is to be paid to:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Enrollee Signature X \_\_\_\_\_

### NAME(S) OF DEPENDENT(S)

Examples of Dependents may include husband, wife, domestic partner, and/or children. Please list all dependent children under age 26 that you wish to include for coverage. The Fund may require additional information on your dependent children and you will be notified accordingly. Any dependent child that is employed and has access to employer-sponsored health coverage is not eligible for coverage. If they are married and their spouse has employer-sponsored health coverage available, your dependent child cannot be added to your coverage.

<u>Name of Dependent</u>	<u>Gender</u>	<u>Dependent's Social Security #</u>	<u>Dependent's Relationship to Enrollee</u>	<u>Dependent's Date of Birth</u>	<u>Marital Status</u>

**The reverse side must be completed if you are including dependents on your coverage**

**EMPLOYER INFORMATION FOR SPOUSE OR DOMESTIC PARTNER**

PLEASE PROVIDE THE FOLLOWING INFORMATION IF APPLICABLE

**Name of Spouse or Domestic Partner**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Gender  Male  
 Female

**Employer for Spouse or Domestic Partner**

Employer Name \_\_\_\_\_

Employer's Telephone # (     ) \_\_\_\_\_

Employer Address - Street \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_

**Insurance Company for Employer of Spouse or Domestic Partner**

Insurance Company Name \_\_\_\_\_

Insurance Company Telephone # (     ) \_\_\_\_\_

Insurance Company Address:

Street \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_

Type of Coverage  Single     Family     Other (Specify) \_\_\_\_\_

Policy I.D. # \_\_\_\_\_ Effective Date of Coverage \_\_\_\_\_

Please check **ALL** coverages provided by Insurance Company for Spouse or Domestic Partner

Medical     Prescription Drug     Chiropractic     Dental     Vision

\*If any of the Dependents listed are the Enrollee's natural children or step-children from a previous marriage, the Enrollee must submit a copy of the Divorce Decree stating which parent or step-parent has custody of the children and which parent or step-parent has financial responsibility for the medical expenses of such children. In the event that any of the Dependents listed above are the Enrollee's natural children or step-children from a previous domestic partnership, the Enrollee must submit a copy of a legal document containing the custodial and financial responsibility information referenced above. If one particular parent or step-parent is responsible for the medical expenses of the children, the Enrollee must provide the name and address of the insurance carrier that presently covers the children.

Name of Parent with Primary Custody \_\_\_\_\_

Name of parent having primary financial responsibility for medical coverage, as determined by Divorce Decree (in the case of a previous marriage) or corresponding legal document (in the case of a previous domestic partnership) \_\_\_\_\_ (The Fund may request a copy of the Divorce Decree or Court Order.)

Name, Address, and Telephone Number of Insurance Carrier providing Primary Coverage:

Insurance Company Name \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Telephone # (     ) \_\_\_\_\_