IRON WORKERS'
Tri-State Welfare Fund

953 American Lane, Suite 100
Schaumburg, IL 60173
Toll-Free: 844-395-4467
Fax: 847-519-1979
www.tristatewelfarefund.com
tristateiron@groupadministrators.com

Dependent Addition Request Form

Please complete and return this form to add a spouse or child to your health care coverage. You must also enclose a CERTIFIED STATE OR COUNTY COPY of your marriage certificate if you are adding a spouse, or a CERTIFIED STATE OR COUNTY COPY of the birth certificate if you are adding a child. If you send originals, they will be copied and returned to you. (A certified copy is a copy acquired from the state or county in which the marriage or birth occurred). Hospital and church records are not acceptable. All information must be completed and provided or your dependent(s) will not be enrolled under your health care coverage.

If you were never married to the mother of the dependent to be added, you must submit either a Voluntary Acknowledgement of Paternity or a Qualified Medical Child Support Order (QMCSO). To add stepchildren or foster children, additional information is required. Please call this office.

Provide the Social Security Number of each dependent you enroll. Federal regulations require health plans to report the names and Social Security numbers of every covered individual to the IRS.

Section A: EMPLOYEE INFORMATION (must be completed) Please print all sections.	
Name	
SSN#	
Address	
City, State, Zip	
Phone Number	
Date of Birth	
Section B: SPOUSE INFORMATION Please print all sections.	
Married Name	
Maiden Name	
SSN#	
Date of Birth	
Marriage Date	
☐ I am enclosing a Certified State or County Copy of my marriage certificate.	

Section C: DEPENDENT INFORMATION Please print all sections.	
1. Child's Full Name	
SSN#	
Date of Birth	
☐ I am enclosing a "Certified State or County Copy" of the birth certificate and Voluntary Acknowledgement of Paternity or Qualified Medical Child Support Order, if applicable.	
2. Child's Full Name	
SSN#	
Date of Birth	
☐ I am enclosing a "Certified State or County Copy" of the birth certificate and Voluntary Acknowledgement of Paternity or Qualified Medical Child Support Order, if applicable.	
3. Child's Full Name	
SSN#	
Date of Birth	
☐ I am enclosing a "Certified State or County Copy" of the birth certificate and Voluntary Acknowledgement of Paternity or Qualified Medical Child Support Order, if applicable.	
4. Child's Full Name	
SSN#	
Date of Birth	
☐ I am enclosing a "Certified State or County Copy" of the birth certificate and Voluntary Acknowledgement of Paternity or Qualified Medical Child Support Order, if applicable.	

- If you have more children to add at this time, please fill out additional information on a separate sheet of paper for each child and enclose birth certificates for each.
- Mail this form and certificates to the address on the top of the first page.

Section D: MEMBER SIGNATURE

All of the information that I have provided is true and correct to my knowledge.

______________________________ ____________

Member's Signature **Date**

Group Administrators, Ltd.

915 National Parkway, Suite F • Schaumburg, IL 60173 • (847) 519-1880 • Fax (847) 519-1979
www.groupadministrators.com

Coordination of Benefits (COB)

It is important that you complete and return this form. COB is a way to coordinate benefit payments when you or your dependents (Spouse, Child) are covered by more than one health/dental/vision plan. By keeping us informed, we can update your records and provide you with timely and accurate processing of claims. Please fill out the information below and return to Group Administrators, Ltd. at the address above. Failure to return this completed form could result in a delay in claim processing.

This information can be updated online by visiting www.Groupadministrators.com, or using the QR code at the bottom of the page.

Section A: Employee Information

Employee Name (Last, First, MI) ID Number

Address City State Zip

Phone Number Email Address:

Do any of your dependents (Spouse, Children) have other medical or dental insurance? **Yes** **No**

If yes, please fill out information below:

Is your Spouse eligible to enroll in an employer-sponsored health plan? **Yes** **No**

Section B: Dependent(Spouse/Child) Information

Name (First, Last)	Insurance Type (Medical, Dental, Vision)	Relationship to Employee	Insurance Name

By signing below I hereby verify that the above statements are true and accurate, and I acknowledge that it is fraudulent to knowingly fill out this form with any information that is false.

Signature Date

If you have any questions, please contact Group Administrators at (847) 519-1880.