IRON WORKERS'
Tri-State Welfare Fund

18861 90th Avenue, Suite A
Mokena, IL 60448
Toll-Free 866-463-9418
Fax 630-967-3080
www.tristatewelfarefund.com
tristate@zenith-american.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	
☐ My child is employed. (Fill in the following information.)	
Child’s Employer	
Employer’s Address	
Employer’s Phone Number	
☐ My child has access to health care coverage through his or her employer. Provider: ________________________ Policy Number: ______________________	
☐ 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	
☐ My child is employed. (Fill in the following information.)	
Child’s Employer	
Employer’s Address	
Employer’s Phone Number	
☐ My child has access to health care coverage through his or her employer. Provider: ________________________ Policy Number: ______________________	
☐ 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**

IRON WORKERS TRI-STATE WELFARE FUND
18861 90th Avenue Suite A
Mokena, IL 60448
630-960-3322
866-463-9418

Member Name: ______________________________________SSN: ___________________

Please answer the following information and return it to the address above.

Are you or any of your dependents covered by another Group Health Plan? ○ Yes ○ No
If Yes, please complete this form, sign and date. If No, sign and date at the bottom.

INSURED INFORMATION

Name of Insured: ____________________________________ SSN: ___________________

Relationship to member: ______________________________ DOB ___________________

INSURANCE CARRIER INFORMATION

Name of Company:____

Address: ______________________________________ Phone #______________________

City: ___________________________________ State: ___________ Zip: ______________

COVERAGE INFORMATION

Type of Plan/Policy: ○ Group ○ Private ○ Other_________________________________

Benefits Included: ☐ Medical ☐ Dental ☐ Ortho ☐ Vision

Family/Dependent Coverage: ○ Yes ○ No

Effective Date: _____________

Termination Date: _____________ Re-instatement Date: _____________

COBRA Continuation: ○ Yes Effective Date: _____________ ○ No

Policy/Group Number:__________________ Status: ○ Active ○ Inactive/Retired

Member Signature ____Date: ____________