IRON WORKERS'
Tri-State Welfare Fund

20 N. Martingale Road, Suite 290
Schaumburg, IL 60173
Toll-Free: 844-395-4467
Fax: 855-978-2331
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 copy of the marriage certificate if you are adding your spouse, or a copy of the birth certificate if you are adding a child. **Original documents are not required**. All information must be completed for each dependent.

To add stepchildren, additional information is required. Please contact 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 Please complete all sections.	
Name	
SSN#	
Address	
City, State, Zip	
Phone Number	
Date of Birth	
Section B: SPOUSE INFORMATION Please complete all sections.	
Married Name	
Maiden Name	
SSN#	
Date of Birth	
Date of Marriage	
☐ I am enclosing a Certified State or County Copy of my marriage certificate.	

Section C: DEPENDENT INFORMATION Please complete all sections.	
1. Child's Full Name	
SSN#	
Date of Birth	
☐ I am enclosing a Certified State or County Copy of the birth	
2. Child's Full Name	
SSN#	
Date of Birth	
☐ I am enclosing a Certified State or County Copy of the birth certificate	
3. Child's Full Name	
SSN#	
Date of Birth	
☐ I am enclosing a Certified State or County Copy of the birth certificate	
4. Child's Full Name	
SSN#	
Date of Birth	
☐ I am enclosing a Certified State or County Copy of the birth certificate	
5. Child's Full Name	
SSN#	
Date of Birth	
☐ I am enclosing a Certified State or County Copy of the birth certificate	

- 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.

20 N. Martingale Rd. Suite 290 Schaumburg, IL 60173 (847) 519-1880 Fax (855) 978-2331
www.groupadministrators.com

Coordination of Benefits Form

Please fill out the information below and return to Group Administrators, Ltd.
Failure to return this completed form may result in a delay in claim processing.
Fax: (855) 978-2331 or Email: cob@groupadministrators.com

What is the purpose of a COB form?

A way to figure out who pays first when 2 or more health insurance plans are responsible for paying the same medical claim.

Employee Information

Employee Name (Last, First, MI) Social Security or ID Number

Address City State Zip

Phone Number Email Address:

Do any of your dependents have other medical or dental insurance, including Medicare? ☐ Yes ☐ No
If yes, please fill out below for each dependent:

Name (First Last)	Insurance type (Medical, Dental, Medicare)	Relationship to employee	Insurance name/effective date

Signature Date

If you have any questions, please contact Group Administrators at (844) 395-4467.