Plumbers and Steamfitters Local Union No 577
Health & Welfare Fund
230 Lexington Green Circle, Suite 400, Lexington, KY 40503
TOLL-FREE: 888-999-7741
FAX: 859-226-1191

Benefits Administered by:
UMR – Attn: Taft-Hartley Department

Employee Enrollment / Change Form

☐ Initial Group ☐ COBRA ☐ Open Enrollment

☐ New Employee ☐ Change (complete change section on reverse side)

EMPLOYER NAME **Plumbers and Steamfitters Local Union No 577 Health & Welfare Fund**	GROUP NUMBER **76411953**	EMPLOYEE START DATE
EMPLOYEE CATEGORY ☐ ACTIVE	☐ EARLY RETIREE	HOURS WORKED WEEKLY

SOCIAL SECURITY NUMBER – –	ALTERNATE IDENTIFICATION NUMBER	
NAME: LAST	FIRST	M. I.
STREET		CITY
STATE	ZIP	EMAIL ADDRESS

DATE OF BIRTH / /	GENDER ☐ M ☐ F	MARITAL STATUS	HOME TELEPHONE NUMBER ( )

Medical Level (select one): ☐ Employee ☐ Family

Do you or any family member currently have other health coverage? If yes to the above question, complete the following:	☐ Yes ☐ Yes, Family ☐ No
Person's Name:	Employer Name:
Carrier Name:	Plan Number:

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

LAST FIRST MI	SS#	BIRTH DATE	GENDER	RELATIONSHIP TO EMPLOYEE
Spouse Name			☐ M ☐ F	
Child(ren) Name 1.			☐ M ☐ F	
2.			☐ M ☐ F	
3.			☐ M ☐ F	
4.			☐ M ☐ F	
5.			☐ M ☐ F	

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COMPLETE THIS SECTION IF MAKING CHANGES.

Effective date of change: _____
Please specify change and update in appropriate section.

☐ Employee name change
☐ Employee address change
☐ Return to work
☐ Other coverage change
☐ Date of Marriage: _____
☐ Date of Divorce: _____
☐ Other: _____
☐ Add dependents
☐ Remove dependents (list names): _____ Reason: _____
☐ Add coverage
☐ State/Federal Continuation

Employee Signature Required: _____

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved.

I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan.

Please refer to your Employee Benefit Booklet for specific detail of your benefit plan.

☐ I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

EMPLOYEE SIGNATURE: _____

DATE: _____