DISTRICT NO. 9, I. A. OF M. & A. W. WELFARE TRUST
12365 St. Charles Rock Road ■ Bridgeton, MO 63044
(314) 739-6442 ■ (888) 739-6442 ■ fax (314) 739-2374 ■ www.d9trusts.org

MEMBER INFORMATION UPDATE FORM

This form must be completed in full by our member and submitted to the Fund Office each calendar year.
You must complete an "Adult Child Eligibility Form" for each dependent child age 19 up to age 26.

It is important for the continued coverage of you and your family that we be informed of any changes in the information.

Member Information

Last Name:	First:	Middle Initial:	Member ID #(Found on Insurance Card):

Home Address:	Check here if a new address. ☐	Gender: ○ Male ○ Female

City, State, Zip:	Home Phone:	Cell Phone:	Date of Birth:

Marital Status: ○ Single ○ Married ○ Widowed ○ Divorced ○ Legally Separated	Employer:

Spouse Information

Last Name:	First:	Middle Initial:	Date of Birth:

Is Spouse Employed: ○ No ○ Yes	If Yes, Employers Name:	Cell Phone:	Gender: ○ Male ○ Female

Does spouse have any other medical coverage? ○ No ○ Yes*	Does spouse have any other dental coverage? ○ No ○ Yes*	Does spouse have a HRA, FSA or HSA with this coverage? ○ No ○ Yes*	***Yes- If you have any other medical and/or dental coverage; you must include a copy of the insurance card(s).**

Medicare Information

List Name of Each Family Member on Medicare:	**Must include a copy of each Medicare card.**

Other Medical Insurance Information

Medical Insurance Carrier Name:	Insured Member:

You must include a copy of all other insurance cards, including Medicare.

List names of each family member covered by this plan.	Insurance Effective Date:

Other Dental Insurance Information

Dental Insurance Carrier Name:	Insured Member:

You must include a copy of all other insurance cards.

List names of each family member covered by this plan.	Insurance Effective Date:

I certify that the above information is true and correct and that any incorrect or inaccurate information can result in a loss of benefits. I understand that misrepresentation in answering the questions on this form may constitute fraud under applicable state and federal statutes. I hereby authorize the Plan to disclose and release any information that may be required by health care providers in order for them to provide the Plan with information needed for the processing of claims and administration of the eligibility and enrollment requirements of the Plan, and I also authorize the disclosure and release of such information by such providers.

Member Signature: _____ Date: _____

List all eligible dependent children under age 19 below.
Adult children (age 19 up to age 26) must complete the "Adult Child Eligibility Form".

Dependent Information

Dependent Name (Last, First, Middle Initial):			Gender: ○ Male ○ Female
Covered By Other Medical Insurance? ○ No ○ Yes	Covered By Other Dental Insurance? ○ No ○ Yes	**Must Include Copy of Card(s)**	Date of Birth:

Dependent Name (Last, First, Middle Initial):			Gender: ○ Male ○ Female
Covered By Other Medical Insurance? ○ No ○ Yes	Covered By Other Dental Insurance? ○ No ○ Yes	**Must Include Copy of Card(s)**	Date of Birth:

Dependent Name (Last, First, Middle Initial):			Gender: ○ Male ○ Female
Covered By Other Medical Insurance? ○ No ○ Yes	Covered By Other Dental Insurance? ○ No ○ Yes	**Must Include Copy of Card(s)**	Date of Birth:

Dependent Name (Last, First, Middle Initial):			Gender: ○ Male ○ Female
Covered By Other Medical Insurance? ○ No ○ Yes	Covered By Other Dental Insurance? ○ No ○ Yes	**Must Include Copy of Card(s)**	Date of Birth:

Dependent Name (Last, First, Middle Initial):			Gender: ○ Male ○ Female
Covered By Other Medical Insurance? ○ No ○ Yes	Covered By Other Dental Insurance? ○ No ○ Yes	**Must Include Copy of Card(s)**	Date of Birth:

Dependent Name (Last, First, Middle Initial):			Gender: ○ Male ○ Female
Covered By Other Medical Insurance? ○ No ○ Yes	Covered By Other Dental Insurance? ○ No ○ Yes	**Must Include Copy of Card(s)**	Date of Birth:

Dependent Name (Last, First, Middle Initial):			Gender: ○ Male ○ Female
Covered By Other Medical Insurance? ○ No ○ Yes	Covered By Other Dental Insurance? ○ No ○ Yes	**Must Include Copy of Card(s)**	Date of Birth:

Dependent Name (Last, First, Middle Initial):			Gender: ○ Male ○ Female
Covered By Other Medical Insurance? ○ No ○ Yes	Covered By Other Dental Insurance? ○ No ○ Yes	**Must Include Copy of Card(s)**	Date of Birth:

Dependent Name (Last, First, Middle Initial):			Gender: ○ Male ○ Female
Covered By Other Medical Insurance? ○ No ○ Yes	Covered By Other Dental Insurance? ○ No ○ Yes	**Must Include Copy of Card(s)**	Date of Birth:

Dependent Name (Last, First, Middle Initial):			Gender: ○ Male ○ Female
Covered By Other Medical Insurance? ○ No ○ Yes	Covered By Other Dental Insurance? ○ No ○ Yes	**Must Include Copy of Card(s)**	Date of Birth:

Dependent Name (Last, First, Middle Initial):			Gender: ○ Male ○ Female
Covered By Other Medical Insurance? ○ No ○ Yes	Covered By Other Dental Insurance? ○ No ○ Yes	**Must Include Copy of Card(s)**	Date of Birth:

Dependent Name (Last, First, Middle Initial):			Gender: ○ Male ○ Female
Covered By Other Medical Insurance? ○ No ○ Yes	Covered By Other Dental Insurance? ○ No ○ Yes	**Must Include Copy of Card(s)**	Date of Birth: