Documents Required For Enrollment

An Enrollment Form must be completed by all new members or to add a dependent to your plan. The fully completed form must be submitted to the Fund Office with any required documentation. Failure to do so in a timely fashion may result in a delay to activate your benefits. It is important for your continued coverage that we be informed of any changes in your information.

All family member names listed must match with the Social Security Administration!

ENROLLING EMPLOYEE ONLY

- Clear copy of Social Security Card*
- Fill out an Enrollment Form.

ENROLLING EMPLOYEE AND SPOUSE ONLY or TO ADD A NEW SPOUSE

- Fill out an Enrollment Form.
  - Clear copy of Social Security Card*
  - Include a copy of your marriage license.

ENROLLING ONE OR MORE CHILDREN (newborn through age 18)

- Fill out an Enrollment Form and include copies of the following documents.
  - **Dependent Child from your current marriage**
    - Birth Certificate of child
    - Clear copy of Social Security Card*
  - **Dependent Child or Stepchild from a Previous Marriage**
    - Clear copy of Social Security Card*
    - Birth Certificate of child
    - The Divorce Decree & Settlement of the natural parents including the petitioner and respondent page, the page showing child's name, page showing custody, page showing who has to maintain insurance (if applicable) and the judges and parents signature page.
  - **Child Born Outside of Marriage**
    - Clear copy of Social Security Card*
    - Birth Certificate of child or Court Order regarding Insurance. Along with the name and date of birth of the other natural parent, including information regarding any other insurance coverage.
  - **Child for Which You are Guardian**
    - Clear copy of Social Security Card*
    - Guardianship / Custody documents.
  - **Adopted Child**
    - Clear copy of Social Security Card*
    - Final Adoption Papers and Birth Certificate of Child.

ENROLLING ONE OR MORE ADULT CHILDREN (age 19 up to age 26)

- Fill out an Adult Child Eligibility Form
  - Clear copy of Social Security Card*
  - Include copy of Birth Certificate

*We can accept a copy of the 1095B in place of social security cards.

NOTE:

- **You have 30 days after your dependent first becomes eligible to provide the required documentation to the Fund Office. After that time, they will be effective for insurance coverage on the date that we receive all necessary paperwork. Please call the District No. 9 Welfare Office at 314-739-6442 or 888-739-6442 if you have any questions.**

ENROLLMENT FORM

This form must be completed in full by our member and submitted to the Fund Office, along with all necessary documents (see attached).
If you have a dependent child age 19 up to age 26, please complete and submit an "Adult Child Eligibility Form".

All family member names listed must match with the Social Security Administration!

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

Section 1: Member Information

Names must match with the Social Security Administration.

Last Name: First: Middle Initial:			Social Security Number:
Date of Birth:	Home Address:		
Home Phone:	Cell Phone:	City: State: Zip Code:	
Gender: ○ Male ○ Female	Employer:	Job Title:	Date Employed:
Marital Status: ○ Single ○ Married ○ Widowed ○ Divorced ○ Legally Separated			

Section 2: Beneficiary Information

Life Insurance and/or Accidental Death and Dismemberment Insurance

All Primary must equal 100%
All Secondary must equal 100%

Last Name, First, Middle Initial:	Date of Birth:	% of Benefit
Address, City, State, Zip:		○ Primary ○ Secondary
Last Name, First, Middle Initial:	Date of Birth:	% of Benefit
Address, City, State, Zip:		○ Primary ○ Secondary
Last Name, First, Middle Initial:	Date of Birth:	% of Benefit
Address, City, State, Zip:		○ Primary ○ Secondary
Last Name, First, Middle Initial:	Date of Birth:	% of Benefit
Address, City, State, Zip:		○ Primary ○ Secondary

Section 3: Spouse Information

If adding spouse include copy of marriage license.

Last Name: First: Middle Initial:			Social Security Number:
Gender: ○ Male ○ Female	**Names must match with the Social Security Administration.**		Date of Birth:
Is Spouse Employed: ○ No ○ Yes	Employers Name:		Date of Marriage:
Does spouse have any other medical coverage? ○ No ○ Yes* If yes, complete Section 5.	Does spouse have any other dental coverage? ○ No ○ Yes* If yes, complete Section 5.	Does spouse have a HRA, FSA or HSA with this coverage? ○ No ○ Yes	

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 hereby authorize doctors, pharmacists, hospital, or other institutions rendering care and treatment to furnish District No. 9 I.A. of M. and A. W. Welfare Trust with full information regarding treatment rendered (including copies of records). I also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish District No. 9, I.A. of M. and A.W. Welfare Trust with information regarding benefits to which I may be entitled. A photo static copy of this authorization shall be considered as effective and valid as the original, and shall remain in effect for a period of one year.

Member Signature:_____ Date:_____

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 ■ email eligibility@d9trusts.org ■ www.d9trusts.org

Section 4:

Dependent Information

List your children under age 19. Include with this form a copy of each child's birth certificate, social security card and if applicable, any legal documents. Must include copy of all other insurance cards.

Adult children aged 19 up to age 26 must complete the "Adult Child Eligibility Form".

Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		
Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		
Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		
Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		
Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		
Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		
Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		

Section 5:

Other Medical Insurance Information

Medical Carrier Name:	Insured Person's Name:
List Name(s) of Each Family Member Covered by this Other Medical Plan:	Effective Date of Coverage:
You must include a front and back copy of all other insurance cards, including Medicare.	
List Name(s) of Each Family Member on Medicare:	

Section 6:

Other Dental Insurance Information

Dental Carrier Name:	Insured Person's Name:
List Name(s) of Each Family Member Covered by this Other Dental Plan:	Effective Date of Coverage:
You must include a front and back copy of all other insurance cards.	