IBEW LOCAL UNION NO 22/NECA HEALTH & WELFARE FUND
HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
ENROLLMENT CARD

Participant's Name: _____ SSN _____-_____-_____

Participant's Date of Birth: _____ Telephone #_____

Participant's Address: _____

_____

Check all applicable boxes: Male ☐ Female ☐

Single ☐ Married ☐ Divorced ☐

*I hereby apply for coverage under the IBEW Local Union No. 22/NECA Health & Welfare Fund Health Reimbursement Arrangement.

Dependent Name	**SS#**	**Date of Birth**	**Sex (M/F)**	**Relationship to Participant**	**Full-Time Student (Y/N)**

*I represent that my answers and statements on this enrollment form are true and complete to the best of my knowledge and belief. I understand that any misrepresentation on this enrollment form may cause the coverage to be void. I further understand that the IBEW Local Union No. 22/NECA Health & Welfare Fund (the "Plan") reserves the right to accept or decline this enrollment form and that no right whatever is created by it. I authorize the Plan to obtain and/or release medical information to the extent necessary for processing claims.

*Signature of Participant: _____ Date: _____

Please provide all applicable documentation to support dependent status, as follows (photo copies are acceptable):

- Marriage Certificate (spouse)
- Birth Certificate (children – all ages)
- Proof of full-time student status (full-time student age 19 through 23)
- Legal Documents Establishing Dependent Status (foster children, children subject to legal guardianships, etc.)
- Dependent Child Enrollment Card (non-student age 19 through 25)—Please contact the Fund Office for a Dependent Child Enrollment Card for dependents age 19 through 25.

Complete and return this form with all applicable documentation to:

IBEW LOCAL UNION NO. 22/NECA
HEALTH & WELFARE FUND
8960 L ST, STE 101,
OMAHA, NE 68127

(402) 593-7565 / (877) 762-9348 toll free / (402) 593-7609 fax