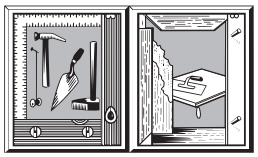

# BAC Local Union 15 Welfare Fund

3100 Broadway, Suite 805 • Kansas City, MO 64111
Phone (816) 777-2668 • Toll Free (833) 479-9428 • Fax (816) 756-3659
BAC-Eligibility@wilson-mcshane.com

*Please complete this form and sign at the bottom of the page. Attach an additional sheet if necessary.*

## Participant Information

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____

## Dependent Child Information

*List all eligible dependent children not currently covered that you are adding to your coverage. Attach an additional sheet if necessary.* ***Please include a copy of their birth certificate. State issued copies only. Souvenir and county copies are not accepted. If the child is a stepchild or if the child's parents are divorced submit a copy of the divorce decree and other court documents specifying who has custody and medical responsibility for the child.***

| **Relationship** (e.g. Son, Stepdaughter) | **Last Name** | **First Name and Middle Initial** | **Date of Birth (MM/DD/YYYY)** | **Social Security Number** | **Does this child have other group coverage? (Including Medicare)** |
|---|---|---|---|---|---|
| | | | | | ☐ **Yes** ☐ **No** |
| | | | | | ☐ **Yes** ☐ **No** |

## Declaration of Other Coverage

*Complete for each dependent above that has other coverage. This information is required for coordination of benefits purposes. Submit a copy of card(s) for each carrier. Attach an additional sheet if necessary*.

Policy Holder: _____ Policy/Group Number: _____

Plan Name & Address: _____

Plan Phone Number: _____

Policy Holder: ☐ Active ☐ Retired Follows Birthday Rule: ☐ Yes ☐ No

Coverage Effective Date: _____ Termination Date: _____

Check Benefits Provided: ☐ Medical ☐ Prescription ☐ Dental ☐ Vision ☐ Mental Health/Substance Abuse

## Acknowledgement

*The Participant must sign below.*

I understand that if I or my dependents provide false information to the BAC Local Union 15 Welfare Fund or conceal information, we could be subject to severe penalties under state and federal law and the Fund may seek to recover benefits wrongfully paid or pursue legal remedies against us. I declare under penalty of perjury that the information provided is true and correct.

Participant's Signature _____ Date _____