



**BAC Local Union 15 Welfare Fund**

3100 Broadway, Suite 805 • Kansas City, MO 64111  
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BAC-Eligibility@wilson-mcshane.com

Please complete the front and back of this form, sign at the bottom of the last page and return. This form can be emailed or faxed to the contact information listed above.

**Participant Information**

Check One:  Male  Female

\_\_\_\_\_  
Last Name First Name Middle Initial

\_\_\_\_\_  
Social Security Number Birth Date (MM/DD/YYYY) Cell Phone Number (\_\_\_\_\_)\_\_\_\_\_

\_\_\_\_\_  
Home Address Apartment Number Home Phone Number (\_\_\_\_\_)\_\_\_\_\_

\_\_\_\_\_  
City County State Zip Code Email Address

Check One:  Single  Married  Widowed  Separated  Divorced: \_\_\_\_\_  
Date of Divorce (MM/DD/YYYY)

Check the following languages in which you are literate:  English  Spanish  Other \_\_\_\_\_

Are you a policyholder of any other group medical, vision or dental plan other than Medicare?  Yes  No

Are you entitled to Medicare Part A or B?  Yes  No If yes, submit a copy of your Medicare Card if it has not been previously submitted.

**Dependent Information**

List all eligible dependents to be covered.

If you are adding a spouse, please include a copy of your marriage certificate. County filed copies only. Souvenir copies are not accepted. If you are adding a child, please include a copy of their birth certificate. State issued copy only. Souvenir copies are not accepted. If either you or your spouse are divorced and you are adding a child or stepchild, submit a copy of the divorce decree and any settlement agreement made part of the decree stating custody and medical responsibility for the children. The decree must be signed and dated by the judge.

Relationship (Spouse, Son, Stepdaughter)	Social Security Number	Last Name	First Name and Middle Initial	Date of Birth (MM/DD/YYYY)	Does this person have other group medical, vision, prescription or dental coverage? (Including Medicare)
Spouse: <input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: This form MUST be signed and dated on page 2 to be valid

If a dependent child or stepchild is listed and the child's parents are divorced or have legal documents regarding medical responsibility and/or custody, submit a copy of the legal document. The document must show where it was filed with the court. Complete the following for each affected child:

Last Name	First Name and Middle Initial	Who has custody?	Who has Medical Responsibility as stated in the legal documents?	Does the child live in your home? <i>If no, please provide the child's home address.</i>
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**Declaration of Other Coverage**

Please complete for the Participant and each dependent that has any other group medical, vision, prescription or dental coverage (including Medicare.) Attach a separate sheet if necessary. Submit a copy of card(s) for each carrier.

<p><b>Other Policy #1</b></p> <p>Policy Holder: _____ Policy or Group Number: _____</p> <p>Policy Holder Social Security Number: _____</p> <p>Does this plan cover dependents? Yes No If yes, who does it cover? List all: _____</p> <p>Plan Name: _____ Employer's Name: _____</p> <p>Plan Address: _____ Plan Phone Number: _____</p> <p>Status of Plan Coverage: Active Retired Follows Birthday Rule*: Yes No</p> <p>Effective Date of Coverage: _____ Termination Date: _____</p> <p>Benefits Provided: Medical: Yes No Prescription: Yes No Dental: Yes No Vision: Yes No</p>
<p><b>Other Policy #2</b></p> <p>Policy Holder: _____ Policy or Group Number: _____</p> <p>Policy Holder Social Security Number: _____</p> <p>Does this plan cover dependents? Yes No If yes, who does it cover? List all: _____</p> <p>Plan Name: _____ Employer's Name: _____</p> <p>Plan Address: _____ Plan Phone Number: _____</p> <p>Status of Plan Coverage: Active Retired Follows Birthday Rule*: Yes No</p> <p>Effective Date of Coverage: _____ Termination Date: _____</p> <p>Benefits Provided: Medical: Yes No Prescription: Yes No Dental: Yes No Vision: Yes No</p>

\*The Birthday Rule is a coordination of benefits rule that some plans use to determine which coverage is primary.

**Acknowledgement**

If married, both the Participant and Spouse must sign below.

I understand that it is my responsibility to immediately notify BAC Local Union 15 Welfare Fund (The Fund) of any changes in the above information. I understand that if I or my dependents provide false information to The Fund, 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 forgoing is true and correct.

**AUTHORIZATION**

I agree, for myself and my dependents, that in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act of omission of another person to fully inform The Fund and that I will execute such assignments, liens or other documents which may be necessary to enable The Fund to recover the value of benefits provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided, I will immediately reimburse The Fund to the extent of services provided and to the extent as specified by the plan. **FRAUD WARNING:** Any person who, knowingly and with intent to defraud the Fund or other person: (1) files an application for benefits or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits, a fraudulent act and may be subject legal action

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse's Signature

\_\_\_\_\_  
Date

FOR INTERNAL USE ONLY

MC REC: \_\_\_\_\_ BC REC: \_\_\_\_\_ DD REC: \_\_\_\_\_ REQ ON: \_\_\_\_\_ BY: \_\_\_\_\_