LiUNA!
WISCONSIN LABORERS' HEALTH FUND
Feel the Power

WISCONSIN LABORERS' HEALTH FUND
WISCONSIN LABORERS' PENSION FUND
BUILDING AND PUBLIC WORKS VACATION FUND

4633 Liuna Way
Suite 201
DeForest WI 53532-2510

MEMBER QUESTIONNAIRE AND BENEFICIARY DESIGNATIONS

This form will replace any questionnaire card on file so you must complete the entire form when making any changes.

MEMBER INFORMATION

NAME (First, M.I. Last)			SOCIAL SECURITY NO.
DATE of BIRTH	SEX ☐ MALE ☐ FEMALE	AREA CODE & TELEPHONE NO.	
MAILING ADDRESS	CITY	STATE	ZIP
MARITAL STATUS ☐ SINGLE ☐ WIDOWED	☐ MARRIED DATE of MARRIAGE_____	☐ DIVORCED DATE of DIVORCE_____	☐ DECLARED DOMESTIC PARTNERSHIP DATE of STATE DECLARATION_____
WHAT IS YOUR CURRENT LOCAL UNION?	HAVE YOU BEEN A MEMBER OF ANY OTHER LOCAL UNION? ☐ YES ☐ NO	WHAT WAS THE OTHER LOCAL UNION NUMBER?	WHEN WERE YOU A MEMBER OF THE OTHER LOCAL UNION?

SPOUSE/DECLARED DOMESTIC PARTNER INFORMATION

Name	Social Security No.	Date of Birth	Medicare Claim No. (HICN)
Does your spouse/declared domestic partner have other insurance coverage? ☐ YES ☐ NO IF YES PLEASE COMPLETE BELOW			
Name Of Insurance Company		Area Code & Telephone No.	
Address		Group No.	
Insured's I.D.	Effective Date	Type of Coverage ☐ FAMILY ☐ SINGLE COVERAGE	
Please check all boxes that apply ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION			

DEPENDENT CHILDREN INFORMATION

List below the name of all eligible children under 26 years of age. Eligible dependents are as defined in the plan document. If relationship of dependent is a child of a declared domestic partner or other, please explain what relationship the dependent is to you.

DEPENDENT First Name / M.I. / Last Name	Social Security No.	Date of Birth MM/DD/YY	RELATIONSHIP (check one) SON	DAUGHTER	STEP SON	STEP DAUGHTER	OTHER (explain)	DOES THIS DEPENDENT LIVE WITH YOU YES	NO ♦

Please provide copies of any court decrees (divorce, paternity, foster child placement or adoption) which apply to custody and/or insurance matters concerning the child(ren).

THIS INFORMATION WILL BE USED TO DETERMINE YOUR DEPENDENTS' ELIGIBILITY STATUS UNDER THE PLAN AND ALSO PRIMARY INSURANCE RESPONSIBILITY.

♦ If any of the children listed as dependents do not live with you, please provide:

Name of person child(ren) reside(s) with _____ Date of Birth _____

Relationship of the person(s) who the child(ren) resides(s) with _____

Address _____
Street City State Zip

YOU MUST COMPLETE THE OTHER SIDE OF THIS FORM

OTHER INSURANCE INFORMATION

SPECIAL INSTRUCTIONS: children who have the same other insurance coverage may be listed together. If this form does not include enough room to list all dependents and other insurance information, please attach a separate paper and follow the format provided. ***Please provide as much, information as possible.***

Are your dependents insured under any other health insurance different from the coverage listed under SPOUSE/DOMESTIC PARTNER INFORMATION? ☐ NO ☐ YES, if Yes, ☐ FAMILY or ☐ SINGLE COVERAGE ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION		
Policyholder's Name		Date of Birth
Relationship of policyholder to your dependent		
List who is covered under this policy name		Medicare HICN
Name of other insurance company		Area Code & Telephone No.
Address		
Effective Date	Group No.	Policy I.D. or Social Security No.

DEATH BENEFITS

NAME YOUR BENEFICIARY – Naming your beneficiary is important and you should update your beneficiary information whenever life events occur.

Beneficiary #1 Name _____ Phone Number _____

Address _____

_____

☐ Pension Fund● ☐ Health Fund ($12,000 Active member, $7,000 Retired member) ☐ Vacation Fund ★(Active member if applicable only)

Beneficiary #2 Name _____ Phone Number _____

Address _____

_____

☐ Pension Fund● ☐ Health Fund ($12,000 Active member, $7,000 Retired member) ☐ Vacation Fund ★(Active member if applicable only)

If you name more than one beneficiary for a specific death benefit, the benefit will be split equally between the listed beneficiaries.

Attach a separate sheet for additional beneficiaries using the above format.

ACCIDENTAL DEATH AND DISMEMBERMENT – Contact fund office or refer to the summary plan description.

● **SUBJECT TO ELIGIBILITY RULES OF THE WISCONSIN LABORERS' HEALTH FUND AND WISCONSIN LABORERS' PENSION FUND.** Contact Building Trades United Pension Trust Fund Office for information regarding Milwaukee Area Pension

★ **SUBJECT TO ELIGIBILITY RULES OF THE BUILDING WORKS VACATION FUND**

MEMBER STATEMENT

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief, true, correct and complete. I agree to promptly notify the fund trustees in writing in the event of: 1) a change in marital status due to divorce or legal separation; 2) the death or disability of a person named here; 3) the birth or adoption of a dependent child; 4) a child's dependent status changes due to age, marriage or financial independence.

I have enclosed copies of the following documentation if required

If you have dependent children:

Living with you ..... ☐ Birth Certificate

Not living with you ..... ☐ Court orders – paternity – Medical coverage

If you have dependent children that are not your son/daughter

☐ Guardianship or Custody Orders

☐ Foster child placement or adoption

☐ Divorce decree – 1st page, signature page, placement and medical coverage sections

If Married, please include marriage certificate

If you are divorced and have dependent children:

☐ Divorce decree – 1st page, signature page, placement and medical coverage sections

If you have a disable child:

☐ Completed incapacitated child form and provide Medicare Claim Number (HICN)

If you have a Declared Domestic Partner:

☐ Certified copy of State Declaration of Domestic Partnership

If you formerly had a Declared Domestic Partner:

☐ Certified copy of Certification of Termination of Domestic Partnership

SIGNATURE _____ DATE _____

THIS FORM MUST BE SIGNED AND DATED BY PARTICIPANT.