Dependent Status Change Information Form

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201 DE FOREST, WI 53532-2510
TELEPHONE: 608-842- 9102 TOLL FREE: 800-397-3373
WEBSITE: WWW.WILBENEFITS.COM

Member's SSN or Member Id: ______________________________

Member's Full Name: ______________________________

Member Phone Number: ______________________________

Member Address: ______________________________ ______________________
Street State, Zip

Member Email Address: ______________________________

Wisconsin Laborers' Health Fund (WLHF) requires immediate notification of individuals who are either new dependents or who are no longer eligible dependents. Failure to promptly notify WLHF may result in the loss of coverage for new dependents and, in the case of former dependents, may result in recovery actions for benefits paid including the loss of right to COBRA continuation coverage. **See Reverse Side of Form for Status Change Codes**

NAME OF DEPENDENT (LAST-FIRST-MIDDLE)	DATE OF BIRTH	TYPE OF STATUS CHANGE	DATE OF MARRIAGE/DIVORCE	RELATIONSHIP	GENDER	SOC. SEC. NO.

DEPENDENT IS ELIGIBLE FOR OTHER GROUP HEALTH PLAN COVERAGE ❑ YES ❑NO
IF YES, NAME OF OTHER GROUP HEALTH PLAN | CARD HOLDER NAME & DATE OF BIRTH | EFFECTIVE DATE (MMADD/YY) MEDICAL, DENTAL VISION (Circle all that apply)

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Please complete, sign and return to WLHF including all applicable documents, as described on the reverse side of form, to support the type of status change for each dependent.

By signing this form, I certify that the information provided is complete and accurate as of the date of my signature.

______________________ Participant Name (please print)

______________________ Participant Signature

______________________ Date

Note: If you would like to make changes to your beneficiaries a Beneficiary Change Form will need to be filled out and returned

Dependent Status Type and Supporting Documentation Needed

Code	Type of Status Change	Required Documentation
1	Marriage	Marriage Certificate
2	Birth / Child (to be added to plan)	Birth Certificate
3	Adding Stepchildren	Birth Certificate and portion of the finalized Judgment of Divorce (when applicable), that includes names of the parties, name of child(ren), who has custody and who has financial responsibility for the child(ren)'s health care expenses. If court documents are not applicable, we will need a notarized letter stating the custodial parent is responsible for all of the child(ren)'s needs along with a brief explanation.
4	Divorce	Finalized Judgment of Divorce – Please only send portions that includes names of the parties, names of children (if any), who has financial responsibility for the child(ren)'s health care expenses, and signature page.
5	Name Change	A copy of one of the following showing name change: driver's license, social security card, or supporting court documents (when applicable)
6	Death	Death Certificate
7	New Insurance Coverage for Dependent	Letter from new insurance showing when coverage started
8	Termination of Dependent Over Age 19	Letter stating reason of termination prior to age 26. Please note that any dependent on your insurance under the age of 19 cannot be removed without supporting court documents.
9	Adoption	Order of Adoption or Order Placing Child After Consent
10	Termination of spouse's insurance plan	Termination notification from spouse's group health, dental or vision insurance plan.
11	Guardianship	Judicial decree granting the guardianship.

Ways to Return Completed Form and Documents

Please make sure all documents are clear and easy to read

Mail:
WLHF Attn: Eligibility
4633 Liuna Way
Deforest, WI 53532

Fax: (608) 846-3192
Attn: Eligibility – Dep Status Change Form

Upload to Website:

1. Visit www.wilbenefits.com
2. Scroll down to upload to Eligibility
3. Browse your device to upload your saved pdf document

Email: Eligibilitywl@benesys.com
Subject: Dependent Status Change Form