Building Trades Welfare Benefit Fund

50 CHARLES LINDBERGH BLVD. SUITE 207
UNIONDALE, NY 11553
516-833-9300

Please complete this form if you, your spouse or other dependents will have other health coverage in addition to your coverage through your employer plan.

Type of Coverage: (Medical, Dental or Both)_____

First Name	Last Name	Relationship	Coverage Effective Date	

Policyholder Name_____

Address:_____

Date of Birth:_____

Insurance Carrier Name_____

Insurance Carrier Address:_____

Member ID# _____

☐ I hereby state that neither myself nor any of my eligible dependents covered under this Plan through my employer are currently covered by another medical, dental or vision plan.

***Signature Required*_____*Date*_____**

RETURN THE COMPLETED FORM TO:

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50 Charles Lindbergh Blvd. Suite 207
Uniondale, NY 11553