Alaska Electrical Health & Welfare Fund
701 E. Tudor, Suite 200
Anchorage, AK 99503
(907) 276-1246 • (800) 478-1246 • FAX (907) 278-7576
www.aetf.com

ANNUAL MEDICAL/DENTAL UPDATE FORM

This form must be filed with the Administrative Office once every 12 months for each participant and each of their dependents.

PARTICIPANT INFORMATION (Participant MUST complete)

Participant's Full Name____ Male____ Female ________

Employee I.D. No.____________________ Birth Date ____________ Home Phone ____________________
or last 4 digits of SSN

Marital Status: Married____ Single ____ Divorced ____ Legally Separated ____ Marriage Date ________ Divorce Date ________

Mailing Address ____
Street City State Zip

Does the participant have any other medical coverage? (Including Medicare) Yes____ No ____ If yes, complete other medical coverage, on page 2

Does the participant have any other dental coverage? Yes____ No ____ If yes, complete other dental coverage, on page 2

DEPENDENT INFORMATION (Complete for each dependent)

Full Name______________________________ Social Security No. ______________________________
or last 4 digits of SSN

Relationship to Participant ____________________ Birth Date ____________________ Male ____ Female ________

If the dependent has a different mailing address than the participant, please complete address section below

Mailing Address____
Street City State Zip

Does the dependent have any other medical coverage? (Including Medicare) Yes____ No ____ If yes, complete other medical coverage, on page 2

Does the dependent have any other dental coverage? Yes____ No ____ If yes, complete other dental coverage, on page 2

CERTIFICATION OF INFORMATION

I certify that the information on this form is correct. I hereby authorize the Plan to disclose and release any information that may be required by health care providers in order for them to provide the Plan with information needed for the processing of medical and dental claims and administration of the eligibility and enrollment requirements of the Plan, and I also authorize the disclosure and release of such information by such providers.

Participant's Signature____ Date______________________________

IMPORTANT! CLAIMS CANNOT BE PROCESSED UNLESS YOU HAVE ANSWERED ALL OF THE ABOVE. INCLUDE PAGE 2 IF THERE IS OTHER MEDICAL OR DENTAL COVERAGE.

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OTHER MEDICAL COVERAGE INFORMATION

Active_____ Retiree_____ COBRA______ Medicare*______

Name of Policy Holder ____

ID No. or Social Security No. ______________________

Birth Date of Policy Holder ______________________

Insurance Company ____

Insurance Company Phone No. ______________________

Effective Date of Coverage ______________________

*If you or your spouse are eligible for Medicare coverage YOU MUST ENROLL IN BOTH PARTS A & B OF MEDICARE

OTHER DENTAL COVERAGE INFORMATION

Active_____ Retiree_____ Cobra_______

Name of Policy Holder ____

ID No. or Social Security No. ______________________

Birth Date of Policy Holder ______________________

Insurance Company ____

Insurance Company Phone No. ______________________

Effective Date of Coverage ______________________