UA Local 190 Plumbers/Pipe Fitters/Service Technicians/Gas Distribution
Health Care Plan
Member Application

A. Coverage Information

Health Coverage: ☐ Yes ☐ No	If YES please check one coverage type: ☐ Employee Only ☐ Emp. & One ☐ Emp. & Two or more

B. Applicant and Family Information

Name: Last First Middle	Are you: ☐ single ☐ married ☐ sep. ☐ div. ☐ widowed	Home Phone number: ( )
Address: Street City State Zip		County

Please complete below for each eligible family member you want covered, including yourself. (Your spouse and any eligible dependents.) Attach a second sheet, if necessary.

Important: In last column, check "yes" **only** if other group health insurance will remain in effect.

First Name Middle Last (if different)	Sex M/F	Relationship to Applicant *	Date of Birth Mo Day Yr	Social Security Number	Totally Disabled	Enrolled in Medicare	Enrolled in other Group Coverage
00 Applicant		**SELF**			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
01 Spouse					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
02 Child					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
03 Child					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
04 Child					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
05 Child					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
06 Child					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

***** If stepchild please complete Part C on Page 2

Medicare Information: If you or any dependents checked YES to being enrolled in Medicare, please give the following Medicare Information and attach copy of Medicare card:

Name	Medicare No.	Part A / Part B eff. Date	Reason for Medicare Eligibility

Application continued on reverse side

Disability Information: If you or any dependents checked YES to being Totally Disabled, please give the following informa-

Name	Describe Disability

C. Stepchildren

If you have listed a step child as a dependent for insurance eligibility purposes, please answer the following questions, and attach copies of adoption/guardian papers or court order.

1. What percentage of the child's annual support do you contribute? _____ %
2. Does the child live in your home full time? ☐ Yes ☐ No
3. Do you claim the child on your federal income tax return as a dependent? ☐ Yes ☐ No

D. Health

Have you, your spouse, or dependent during the last five years;

1. Consulted, been examined or treated by a physician or practitioner? ☐ Yes ☐ No

Name	Reason	Date of Service	Physicians Name & Address, PA#

2. Had a X-ray, electrocardiogram or lab tests? ☐ Yes ☐ No

Name	Reason	Date of Service	Physicians Name & Address, PA#

3. Used cocaine, heroin, morphine, LSD, marijuana, PCP, or any other hallucinogenic or narcotic drug? ☐ Yes ☐ No

E. Certification

I certify that the above information contained in this application is correct to the best of my knowledge and belief.

X _____ **X** _____

Applicants Signature Date