Plumbers and Pipefitters Local Union No. 421
Health and Welfare Plan

2020 DEPENDENT VERIFICATION FORM

Employee Name:		**Social Security Number:**		**Date of Birth:**	
Employee Mailing Address:				**Phone #:**	

If you have enrolled your spouse in the Plan, please complete the following section regarding your spouse.

Name of Spouse	**Date of Birth**	**SSN**	**Is your spouse employed? (Answer Yes or No)**	**If your spouse is employed, please provide the employer's name and phone number.**	
				Name:	Phone #:

If your spouse is employed, does the employer offer group health insurance coverage? (Answer Yes or No)	**If your spouse's employer offers group health insurance coverage, is there a cost to your spouse to enroll? (Answer Yes, No or N/A)**	**Does your spouse have other health insurance coverage? (Answer Yes or No)**	**If your spouse has other health insurance coverage, please provide the requested information below.**	
			Coverage Effective Date:	Insurance Carrier Name:
			Insurance Carrier Phone #:	Policy Identification #:

If you have enrolled your children in the Plan, please complete the following sections.

Name of Child	**Date of Birth**	**SSN**	**Does your Child have other insurance coverage? (Answer Yes or No)**	**If your child has other insurance coverage, please provide the requested information below.**		
				Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:

				Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:
				Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:
Dependent Children Information continued…						
Name of Child	**Date of Birth**	**SSN**	**Does your Child have other insurance coverage? (Answer Yes or No)**	**If your child has other insurance coverage, please provide the requested information below.**		
				Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:
				Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:

If you wish to complete a paper form and would like to return it to NEBA using the secure upload feature on the NEBA website, please visit https://www.nebainc.com/send-secure-file/ **and select 'Delivery To' Enrollment. Using a computer, your completed form may be scanned and securely uploaded via the website. You can also use your smart phone to take pictures of the completed form and upload them through the website using your Photo Library. Please contact NEBA's Enrollment Department at (800) 842-5899 if you have any questions.**

Employee Signature:

I certify that the information provided on this Dependent Verification Form is true to the best of my knowledge and that the dependents I have enrolled meet the Plan's definition of Dependent.

I understand that it is my responsibility to notify the Plan Administrator within sixty (60) days of a divorce or legal separation from my spouse. **Failure to notify the Plan is a material misrepresentation of eligibility.**

Any material misrepresentation to the Plan may result in the termination of the employee and dependent's health coverage.

Employee Signature: _____ Date: _____