

BAC INTERNATIONAL HEALTH FUND INSURANCE CHANGE FORM

POS _____ **PPO** _____

(Do not write in shaded area)

ACCOUNTING/DIVISION CODE _____ PLAN _____

CHANGE EFFECTIVE DATE:		LOCAL / LOCATION :
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Medical Group Number: 195858	Dental Group Number: 516220	Vision Group Number: 02109592
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MEMBER'S LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH : MO	DAY	YEAR
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ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE
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DATE OF UNION MEMBERSHIP	SOCIAL SECURITY NUMBER	I.U. NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
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OTHER INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	IF MEDICARE ELIGIBLE <input type="checkbox"/> "A" <input type="checkbox"/> "B"	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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MEMBER STATUS: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Medicare <input type="checkbox"/> COBRA <input type="checkbox"/> Non-Job Site	STATUS CHANGE: From _____ to _____ Date: _____
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Type of coverage : Please check one Member only Member + Spouse Member + Spouse + Child(ren) Member + Child(ren) only

DEATH BENEFITS TO BE PAID TO : (Full Name)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	RELATIONSHIP	TELEPHONE
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ADDRESS OF BENEFICIARY (Street, City, State, Zip)

MEDICAL-DENTAL-VISION INSURANCE: subject to the provision of your Local

I understand that this enrollment form must be completed, signed and returned to the Fund office timely to avoid any delays in coverage. It is unlawful for a participant or dependent(s) or other individual(s) to knowingly and intentionally provide false, incomplete or misleading facts or information on this enrollment form for the purpose of defrauding or attempting to defraud the BAC IHF with regards to the application for benefits or claim for benefits. Penalties may include, but are not limited to, denial of benefits and repayment of moneys fraudulently paid on behalf of ineligible dependents.

DEPENDENTS TO BE COVERAGE

ALL NEWLY ELIGIBLE PARTICIPANTS MUST SHOW PROOF OF DEPENDENT COVERAGE. EXAMPLES: BIRTH CERTIFICATE, MARRIAGE CERTIFICATE, OR AFFIDAVIT OF COMMON LAW MARRIAGE IN COMMON LAW MARRIAGE STATES. FORMS WILL NOT BE PROCESSED IF PROOF OF DEPENDENT COVERAGE IS NOT ATTACHED.

TYPE OF COVERAGE DESIRED :

Employee Only Employee + 1 Dependent Employee + Family

DEPENDENTS TO BE COVERED

DEPENDENT NAME	SOCIAL SECURITY NUMBER	SEX M / F	DATE OF BIRTH		SPOUSE MEDICARE	
Spouse					<input type="checkbox"/> "A" <input type="checkbox"/> "B"	
Child					STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
Child					STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
Child					STUDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	

OTHER INSURANCE INFORMATION

MEDICAL Names of those covered	Name/Address of Insurance Company	Effective Date/Policy Number	
DENTAL Names of those covered	Name/Address of Insurance Company	Effective Date/Policy Number	

SIGNATURE OF MEMBER _____ DATE _____