DEPENDENT COVERAGE VERIFICATION FORM

PLUMBERS & PIPEFITTERS LOCAL UNION #101 WELFARE FUND OFFICE
ADULT CHILD DEPENDENT EMPLOYMENT FORM
4600 46th Avenue; Rock Island, Illinois 61201 (309) 794-1170 (Option #2) Fax (309) 788-8335

Member Name: ______________________________

Dependent Name: ______________________________

Dependent Address: ______________________________

Dependent City: ____________________ State: _________ Zip: __________

Dependent Phone Number: ____________________ Dependent Birth Date: _____/_____/_____
Month Day Year

ADULT CHILD - **Dependents Employment**

Are you employed? ☐ Yes ☐ No (complete bottom of form)

If employed please have your employer complete employer information and sign.

Name of Employer: ______________________________

Address: ____________________ Phone ____________________

City: ____________________ State: __________ Zip__________

Is the said above employee covered by any work sponsored insurance benefits?
Medical/Prescription Drug Coverage: ☐ Yes ☐ No Dental Coverage: ☐ Yes ☐ No Vision Coverage: ☐ Yes ☐ No
Effective date of insurance:____________________

I hereby certify the person on this form is an employee of the Employer above and the information supplied by the employee is accurate and complete to the best of my knowledge.

____

Employer Representative Signature Phone Number

____

Employer Representative (please print) Title/Position

Dependent's Marital Status/ Other Insurance Offered

☐ Single

☐ Married: Date of Marriage: ______/______/______ Name of Spouse: ____________________

If married is spouse employed: ☐ Yes ☐ No

If yes: is spouse offered insurance: ☐ No ☐ Yes ☐ Single Coverage or ☐ Family Coverage

Effective date of Coverage:____________________

Employer of Spouse: ______________________________

Contact Person____________________ Phone Number____________________

____

Dependent's Signature Date