T 317.923.4577 | **F** 317.923.7633 | **E** info@ewbtf.org

1828 North Meridian Street – Suite 103, Indianapolis, IN 46202

Participant Information									
Name:		**SSN:**				**Date of Birth:**			
Address:									
City:		**State:**				**Zip:**			
Cell Phone:		**Email Address:**							
Would you like electronic copies of plan documents?				Yes		No			
Marital Status:	Single	Married		Divorced		Separated		Widowed	
Are you Medicare Eligible?	Yes	No	*If Yes, do you have*			Part A	Part B	Part D	
Are you covered by any other plan that would be primary?						Yes		No	
If Yes, is the coverage (circle one)						Family		Single	
If Yes, is the policy (circle all that apply)		Medical	Prescription		Dental		Vision		
Name of Insurance						**Effective Date**			
Medical:									
Prescription:									
Dental:									
Vision:									

Spouse Information									
Name:		**SSN:**				**Date of Birth:**			
Address:									
City:		**State:**				**Zip:**			
Cell Phone:		**Email Address:**							
Are you Medicare Eligible?	Yes	No	*If Yes, do you have*			Part A	Part B	Part D	
Are you covered by any other plan that would be primary?						Yes		No	
If Yes, is the coverage (circle one)						Family		Single	
If Yes, is the policy (circle all that apply)		Medical	Prescription		Dental		Vision		
Name of Insurance						**Effective Date**			
Medical:									
Prescription:									
Dental:									
Vision:									

Dependent Information									
Name:		**SSN:**				**Date of Birth:**			
Name:		**SSN:**				**Date of Birth:**			
Name:		**SSN:**				**Date of Birth:**			
Name:		**SSN:**				**Date of Birth:**			
Name:		**SSN:**				**Date of Birth:**			
Are any of these dependents covered under another insurance plan? *(other than what is listed above in the Spouse Section)*						Yes		No	
If Yes, is the policy (circle all that apply)		Medical	Prescription		Dental		Vision		
Name of Insurance						**Effective Date**		**Policyholder's Name**	
Medical:									
Prescription:									
Dental:									
Vision:									

PLEASE READ CAREFULLY AND SIGN BELOW I hereby certify that the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentionally falsify or fail to give any of the information on this form, claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of the change.

Signature of Participant:	Date:
Signature of Spouse:	Date: