



# IRON WORKERS'

## Tri-State Welfare Fund

333 Pierce Road, Suite 410  
 Itasca, Illinois 60143  
 Toll-Free 866-463-9418  
 Fax 630-967-3080  
[www.tristatewelfarefund.com](http://www.tristatewelfarefund.com)  
 tristate@abpa-tpa.com

### DEPENDENT ADDITION REQUEST FORM

Please complete and return this form to add a spouse or child to your health care coverage. You must also enclose a CERTIFIED STATE OR COUNTY COPY of your marriage certificate if you are adding a spouse, or a CERTIFIED STATE OR COUNTY COPY of the birth certificate if you are adding a child. If you send originals, they will be copied and returned to you. (A certified copy is a copy acquired from the state or county in which the marriage or birth occurred). Hospital and church records are not acceptable. All information must be completed and provided or your dependent(s) will not be enrolled under your health care coverage. **If you were never married to the mother of the dependent to be added, you must submit either a Voluntary Acknowledgement of Paternity or a Qualified Medical Child Support Order (QMCSO). To add stepchildren or foster children, additional information is required. Please call this office.**

I am adding the following person(s) to my health coverage. Check all that apply.

- Spouse.** I would like to add my spouse to my health coverage. [Complete Sections A and B and sign Section D on the back.]
- Child.** I would like to add my child/children to my health coverage. If your child has employer-sponsored coverage, your child is not eligible for coverage under this Plan. [Complete Sections A and C and sign Section D on the back.]
- Both.** I would like to add my spouse and child/children to my health coverage. [Complete Sections A-C and sign Section D on the back.]

#### Section A: EMPLOYEE INFORMATION (must be completed) Please print all sections.

NAME	
SSN#	- -
ADDRESS	
CITY, STATE, ZIP	
PHONE NUMBER	( ) -
DATE OF BIRTH	/ /

#### Section B: SPOUSE INFORMATION Please print all sections.

MARRIED NAME	
MAIDEN NAME	
SSN#	
DATE OF BIRTH	/ /
MARRIAGE DATE	/ /

- I am enclosing a **Certified State or County Copy** of my marriage certificate.

**Section C: DEPENDENT INFORMATION Please print all sections.**

1. CHILD'S FULL NAME	
SSN#	
DATE OF BIRTH	
<input type="checkbox"/> My child is employed. (Fill in the following information.)	
CHILD'S EMPLOYER	
EMPLOYER'S ADDRESS	
EMPLOYER'S PHONE NUMBER	
<input type="checkbox"/> My child has access to health care coverage through his or her employer. Provider: _____ Policy Number: _____	
<input type="checkbox"/> I am enclosing a <b>Certified State or County Copy</b> of the birth certificate and Voluntary Acknowledgement of Paternity or Qualified Medical Child Support Order, if applicable.	
2. CHILD'S FULL NAME	
SSN#	
DATE OF BIRTH	
<input type="checkbox"/> My child is employed. (Fill in the following information.)	
CHILD'S EMPLOYER	
EMPLOYER'S ADDRESS	
EMPLOYER'S PHONE NUMBER	
<input type="checkbox"/> My child has access to health care coverage through his or her employer. (Fill in below.) Provider: _____ Policy Number: _____	
<input type="checkbox"/> I am enclosing a <b>Certified State or County Copy</b> of the birth certificate and Voluntary Acknowledgement of Paternity or Qualified Medical Child Support Order, if applicable.	

\*\*\* If you have more children to add at this time, please fill out additional information on a separate sheet of paper for each child and enclose birth certificates for each.

\*\*\* Mail this form and certificates to the address on the top of the first page.

**Section D: MEMBER SIGNATURE**

**All of the information that I have provided is true and correct to my knowledge.**

Member's Signature \_\_\_\_\_

Date \_\_\_\_\_