

**Alaska Electrical Health & Welfare Fund**  
**2600 Denali Street, Suite 200**  
**Anchorage, AK 99503-2782**  
**(907) 276-1246 • (800) 478-1246 • FAX (907) 278-7576**

## ENROLLMENT/CHANGE FORM

**PURPOSE FOR COMPLETING FORM**

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| <input type="checkbox"/> New Employee<br><input type="checkbox"/> Address Change<br><input type="checkbox"/> Change of Dependents<br><input type="checkbox"/> Beneficiary Change | <input type="checkbox"/> Name Change (previous name) _____<br><input type="checkbox"/> Marriage (date of marriage) _____<br><input type="checkbox"/> Divorce (date of divorce) _____<br><input type="checkbox"/> Other _____ |
|--|--|

**EMPLOYEE IDENTIFICATION**

First Name	Initial	Last Name
Mailing Address	City	State
Social Security Number	Date of Birth	Sex
Phone Number	Marital Status (M/S/D)	Marriage Date
Zip Code		

**SPOUSE IDENTIFICATION**

First Name	Initial	Last Name	Social Security Nu	Date of Birth	Sex	Other Coverage Medical (Y/N)	Dental (Y/N)
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**DEPENDENT CHILDREN**

First Name	Initial	Last Name	Social Security Number	Date of Birth	Sex	Relationship	Other Coverage Medical (Y/N)	Dental (Y/N)

**BENEFICIARY DESIGNATION (Life Insurance)**

First Name	Initial	Last Name	Relationship	Percent of Benefits (must total 100%)

If you have not already done so, please attach true copies of appropriate marriage certificate, dependent birth certificates, court approved adoption papers, child custody decrees, and/or divorce decree. This information will be used to determine eligibility for claim/benefit purposes. I hereby certify that the above information is true, correct and complete to the best of my knowledge.

Employee Signature	Date
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**PLEASE COMPLETE AND RETURN AS SOON AS POSSIBLE AS FAILURE TO DO SO  
MAY DELAY THE PROCESSING OF YOUR CLAIMS**