

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

ANNUAL MEDICAL/DENTAL UPDATE FORM

**This form must be filed with the Administrative Office once every 12 months
for each participant and each of their dependents.**

PARTICIPANT INFORMATION (Participant MUST complete)

Participant's Full Name _____ Male _____ Female _____

Employee I.D. No. _____ Birth Date _____ Home Phone _____
or last 4 digits of SSN

Marital Status: Married _____ Single _____ Divorced _____ Legally Separated _____ Marriage Date _____ Divorce Date _____

Mailing Address _____
Street City State Zip

Does the participant have any other medical coverage? Yes _____ No _____ If yes, complete other medical coverage, on page 2
(Including Medicare)

Does the participant have any other dental coverage? Yes _____ No _____ If yes, complete other dental coverage, on page 2

DEPENDENT INFORMATION (Complete for each dependent)

Full Name _____ Social Security No. _____
or last 4 digits of SSN

Relationship to Participant _____ Birth Date _____ Male _____ Female _____

If the dependent has a different mailing address than the participant, please complete address section below

Mailing Address _____
Street City State Zip

Does the dependent have any other medical coverage? Yes _____ No _____ If yes, complete other medical coverage, on page 2
(Including Medicare)

Does the dependent have any other dental coverage? Yes _____ No _____ If yes, complete other dental coverage, on page 2

CERTIFICATION OF INFORMATION

I certify that the information on this form is correct. I hereby authorize the Plan to disclose and release any information that may be required by health care providers in order for them to provide the Plan with information needed for the processing of medical and dental claims and administration of the eligibility and enrollment requirements of the Plan, and I also authorize the disclosure and release of such information by such providers.

Participant's Signature _____ Date _____

**IMPORTANT! CLAIMS CANNOT BE PROCESSED UNLESS YOU HAVE ANSWERED ALL OF THE ABOVE.
INCLUDE PAGE 2 IF THERE IS OTHER MEDICAL OR DENTAL COVERAGE.**



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OTHER MEDICAL COVERAGE INFORMATION

Active _____ Retiree _____ Cobra _____ Medicare* _____

Name of Policy Holder _____

ID No. or Social Security No. _____

Birth Date of Policy Holder _____

Insurance Company _____

Insurance Company Phone No. _____

Effective Date of Coverage _____

*If you or your spouse are eligible for Medicare coverage YOU MUST ENROLL IN BOTH PARTS A & B OF MEDICARE

OTHER DENTAL COVERAGE INFORMATION

Active _____ Retiree _____ Cobra _____

Name of Policy Holder _____

ID No. or Social Security No. _____

Birth Date of Policy Holder _____

Insurance Company _____

Insurance Company Phone No. _____

Effective Date of Coverage _____