Alaska Electrical Health & Welfare Fund
701 E. Tudor, Suite 200
Anchorage, AK 99503
(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 _____

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

Mailing Address _____
Street City State Zip

Email Address _____

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

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? (Including Medicare) Yes ☐ No ☐ If yes, complete other medical coverage, on page 2

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 _____