Sheet Metal Workers' Local 36 Benefit Funds
2319 Chouteau Ave., Ste. 300
St. Louis, MO 63103
Phone 314-652-8175 / Fax 314-652-0338 / Toll Free 800-741-9411

Adult Dependent Children Election Form

(Dependents Age 19 and Older regardless of student status)

Primary Member Information

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth:	
Home Address:	City:	State:
Zip Code:	Daytime Phone Number:	

Primary Spouse's Information

Last Name:	First Name:	Middle Initial:
Date of Birth:	Employer:	
Are You Covered by Another Plan? YES NO	Are Dependents Covered on this Plan? YES NO	
Name of Plan:	Maximum age for dependent coverage?	

Adult Dependent Children's Information

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth:	
Home Address:	City:	State:
Zip Code:	Phone Number:	
Is dependent child married?: YES NO	Name of dependent's Spouse:	
Dependent Spouse's Employer Name:	Dependent Spouse's Employer Phone:	
Spouse's Employer Address:	City/State/Zip:	
Has dependent elected coverage through spouse's employer?: YES NO		
Is dependent child currently employed? YES NO		
Has dependent elected health insurance coverage through his/her employer?: YES NO		
Employer Name:	Employer Phone:	
Employer Address:	City/State/Zip:	

If dependent child or their spouse is employed, you **MUST** provide a letter from his/her current employer stating that either a. health insurance is **available** to him/her through their own active employment or b. health insurance is **not available** to him/her through your own active employment. This letter must be on company letterhead. This information must be available upon request in the future as it will be subject to periodic audit.

Signature of Member: ______________________ Date: ______________

Signature of Dependent Child: ______________________ Date: ______________

(Additional Dependents)

Adult Dependent Child Information

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth:	
Home Address:	City:	State:
Zip Code:	Phone Number:	
Is dependent child married?: YES NO	Name of Spouse:	
Spouse's Employer Name:	Spouse's Employer Phone:	
Spouse's Employer Address:	City/State/Zip:	
Has dependent elected coverage through spouse's employer?: YES NO		
Is dependent child currently employed? YES NO		
Has dependent Child elected health insurance coverage through his/her employer?: YES NO		
Employer Name:	Employer Phone:	
Employer Address:	City/State/Zip:	

If dependent child or their spouse is employed, you **MUST** provide a letter from his/her current employer stating that either a. health insurance is **available** to him/her through their own active employment or b. health insurance is **not available** to him/her through your own active employment. This letter must be on company letterhead. This information must be available upon request in the future as it will be subject to periodic audit.

Signature of Dependent: ______________________ Date: ______________

Adult Dependent Information

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth:	
Home Address:	City:	State:
Zip Code:	Phone Number:	
Is dependent child married?: YES NO	Name of dependent child's Spouse:	
Spouse's Employer Name:	Spouse's Employer Phone:	
Spouse's Employer Address:	City/State/Zip:	
Has dependent child elected coverage through their spouse's employer?: YES NO		
Is dependent child currently employed? YES NO		
Has dependent elected health insurance coverage through his/her employer?: YES NO		
Employer Name:	Employer Phone:	
Employer Address:	City/State/Zip:	

If dependent child or their spouse is employed, you **MUST** provide a letter from his/her current employer stating that either a. health insurance is **available** to him/her through their own active employment or b. health insurance is **not available** to him/her through your own active employment. This letter must be on company letterhead. This information must be available upon request in the future as it will be subject to periodic audit.

Signature of Dependent: ______________________ Date: ______________