North Atlantic States
CARPENTERS BENEFIT FUNDS
Health
Benefits Fund

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HRA Enrollment Form

Important Notice Regarding Coverage Changes:
If you experience any changes to your marital status, your spouse's coverage, or any other insurance coverage—or if you need to add or remove a dependent—you **must** complete a new form within **30** days of the event. Failure to do so will require you to wait until the next ***Open Enrollment*** period to make changes.

Please note:
- No reimbursements will be issued for dependents **not** listed on the form.
- Coverage is only available for dependents up to age 26.
- You **must** provide Social Security numbers and details of any other coverage for all listed dependents.

Member Information (please print)

Please use date format: mm/dd/yyyy

Name: _____ last four of SSN: _____

Address: _____

Email: _____ Primary Contact number: _____ Date of Birth: _____

(select one) ◯ Married ◯ Single ◯ Divorced Marriage/Divorce date: _____

Spouse's Information (please print)

Name: _____ last four of SSN: _____

Date of Birth: _____

Other Coverage (please print)

Do you, your spouse, or your dependent(s) have other insurance benefits? (select one) ◯ Yes ◯ No

If yes, coverage is through: (select one) ◯ Self ◯ Spouse ◯ Dependent

Name of insurance company: _____

Effective date: _____ Term Date: _____

Medical: ◯ Single ◯ Two-person ◯ Family / Whom does plan cover?: _____

Dental: ◯ Single ◯ Two-person ◯ Family / Whom does plan cover?: _____

Optical: ◯ Single ◯ Two-person ◯ Family / Whom does plan cover?: _____

Dependent Children Information (please print)

Dependent's Name (include last name if different)	Date of Birth	Relationship to Member	last four of SSN

By signing below, I certify that the above information I have provided is true and correct.

Member Signature: _____ **Date:** _____