Annual Continued Eligibility Verification Form

This form must be completed by each participant every year and is due by **April 30th, 2025**. All claims submitted after that date will not be processed until this and any other necessary documentation requested has been received by the Fund Office.

Participant Name: _____

Participant SSN: _____-___ -_____ **Participant Date of Birth :** ____/____/_____

Participant Sex: _____ **Male** _____ **Female**

Participant Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email Address: _____

Current Marital Status:

Single _____

Married _____ Date of Marriage:_____

Separated _____ Date of Separation: _____

Divorced _____ Date of Divorce: _____

Widowed _____

PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING YOUR SPOUSE/ DEPENDANTS:

Spouse's Name: _____

Spouse's SSN: _____-_____-_____ **Spouse's Date of Birth:** ____/____/_____

Is your Spouse Employed? Yes _____ No_____

Do you or your spouse have Medicare benefits due to disability? Yes _____ No _____ If Medicare answer is yes, please submit a copy of the Medicare benefit card to the Fund Office

Dependent Name: _____ DOB: ____/____/_____ SSN: ____-____-_____

Dependent Name_____ DOB: ____/____/_____ SSN: ____-____-_____

Dependent Name: _____ DOB: ___/____/_____ SSN: ____-____-_____
Dependent Name: _____ DOB: ___/____/_____ SSN: ____-____-_____
*Please continue on the back if needed

I declare that the information is true and correct to the best of my knowledge, information and belief. I understand that the fund reserves the right to suspend or terminate my health coverage if it concludes that I have provided false or misleading information in this declaration.

Date: _____

Participant Signature: _____

Spouse Signature: _____