UA Local 190 Plumbers/Pipefitters/Service Technicians/Gas Distribution Health Care Plan
Member Change Authorization

A. Member Information

Name: Last	First	Middle	Social Security No.

Member Address: Street City State Zip
☐ check if this is a new address

B. Change Information

Complete only the sections that apply to the change(s) you wish to make.

1. **Change Coverage Type** to:
☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child ☐ Family

2. **Add/Delete Dependents**: List each dependent you want added to, removed from, your coverage. (Use a second Change Authorization Form if necessary)

Important: In last column, check "yes" only if other group health insurance will remain in effect

Check One Add	Delete	First Name Middle Last (if different)	Sex M/F	Relationship to Member *	Date of Birth Mo Day Yr	Social Security Number	Totally Disabled	Enrolled in Medicare	Enrolled in other Group Coverage
☐	☐	00 Applicant		**SELF**			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐	☐	01 Spouse					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐	☐	02 Child					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐	☐	03 Child					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐	☐	04 Child					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐	☐	05 Child					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐	☐	06 Child					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

***** If stepchild please complete Part C on Page 2

Medicare Information: If you or any dependents checked YES to being enrolled in Medicare, please give the following Information and attach copy of Medicare card:

Name	Medicare No.	Part A / Part B Eff. Date	Reason for Medicare Eligibility

Form continued on reverse side.

Disability Information: If you or any dependents checked YES to being Totally Disabled, please give the following information:

Name	Describe Disability

3. **Change Name**

From: Last First Middle	To: Last First Middle

4. **Reason for Change(s)** (check all that apply)

☐ Member's Marriage ☐ Member's Divorce ☐ Enrollment in Medicare ☐ Adding Newborn Child

☐ Child reached dependent age limit ☐ Disenrollment in Medicare ☐ Child's Marriage

☐ Adoption/ legal custody of child (attach required legal documents) ☐ Retirement ☐ Death

☐ Other:

C. Stepchild Questions

If you have listed a step child as a dependent for insurance eligibility purposes, please answer the following questions and attach copies of adoption/guardian papers or court order.

1. What percentage of the child's annual support do you contribute? _____ %
2. Does the child live in your home full time? ☐ Yes ☐ No
3. Do you claim the child on your federal income tax return as a dependent? ☐ Yes ☐ No

D. Certification

I Certify that the above information contained in this form is correct to the best of my knowledge and belief.

X_____ **X**_____

Member Signature Date