Change Request Form

Construction Laborers' Welfare Fund
2357 59th Street • St. Louis, MO 63110

It is hereby requested that the changes listed below be made to my records. Be sure to print all information. These changes shall apply only to benefits offered by the Greater St. Louis Construction Laborers' Welfare Fund.

INFORMATION

Member Name: _____ Member ID #: _____

Member's Local:_____ Email:_____

Member's Date of Birth:_____

The request applies to: ○ Member ○ Dependent ○ All Family Members

List the dependent(s) this change is applicable to:

Spouse's Name: _____ SSN: XXX-XX-_____ Date of Birth: ___/___/___

Child's Name: _____ SSN: XXX-XX-_____ Date of Birth: ___/___/___

Child's Name: _____ SSN: XXX-XX-_____ Date of Birth: ___/___/___

Child's Name: _____ SSN: XXX-XX-_____ Date of Birth: ___/___/___

TERMINATE MEDICARE SUPPLEMENT/RETIREE BENEFITS

Effective date of change: _____

Select the participant and/or dependent you wish to terminate: ○ Member ○ Spouse ○ Child(ren)

O I elect to ***terminate*** the Medical Supplement coverage and I understand in order to reinstate I must meet the qualifications as stated in the Summary Plan Description.

O I elect to ***terminate*** the Retiree coverage and I understand in order to reinstate I must meet the qualifications as stated in the Summary Plan Description.

Please note: Changes must be in by the 15th of the month in order to be reflected on this month's pension check.

I understand that it is my responsibility to immediately notify the Benefit Office of any changes in the above information. If there is not an effective date of change indicated on this form, we will use the date on which the Change Request Form is signed unless the Summary Plan Description book states otherwise. I certify the above statements are true, complete, and accurate to the best of my knowledge. A photocopy of this authorization shall be as valid as the original.

Member Name: _____ Date: _____

Member Signature: _____ Date: _____