LABORERS' BENEFITS • ST. LOUIS

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: _____ Medical 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: ___/___/___

CHANGE OF ADDRESS/PHONE NUMBER

Effective date of change: _____

_____ New Address	_____ Old Address
_____ City, State, Zip	_____ City, State, Zip
_____ New Phone Number	_____ Old Phone Number

ADD/REMOVE DEPENDENT

Effective date of change: _____ ○ Add ○ Remove

Name: _____ SSN: _____ Date of Birth: ___/___/___

Name: _____ SSN: _____ Date of Birth: ___/___/___

Name: _____ SSN: _____ Date of Birth: ___/___/___

Reason for adding/removing dependent:_____

See reverse side for required signature.

2357 59th Street St. Louis, Missouri 63110-2811
(314)644-2777 1-800-489-0228 Fax: (314)646-4440

ADD A NEWBORN

Date of Birth: _____ Newborn's Name: _____ Sex: ○ M ○ F

Natural Father's Name: _____ Natural Mother's Name: _____

If you fail to submit a completed enrollment form or any required documentation other than a birth certificate within **31 days** after you acquire a dependent or a birth certificate with **90 days** after the birth of a child, coverage for that dependent will be effective the first of the month following receipt of the completed enrollment for, birth certificate or other required documentation.

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 Signature: _____ Date: _____

Signature: _____ Date: _____

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