IUB & ALLIED CRAFTWORKERS CT HEALTH FUND
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PO Box 1175, Albany NY 12201-1175
(p) 833-502-0444 · (e) BACHealthHours@cap-rx.com

IUBAC Health Fund – Capital Rx Member Enrollment Form

☐ New Group ☐ Open Enrollment	☐ Change Request ☐ Waive Coverage	Location:	Job Title:	Group # ☐ Salary ☐ Hourly ☐ Retired
Date of Hire:	Effective Date :	Dept.	SSN#:	
Last Name:	First Name:	MI:	Date of Birth:	
Street Address:			Gender: ☐ M ☐ F	
City:	State:	Zip:	Other Insurance: ☐ No ☐	
Home Phone:	Email:	Marital Status: ☐ Single ☐ Married ☐ Divorced		

Dependent Information
Please complete all fields, if more space is needed use the back of this form. If you are waiving all coverage, Dependent Information is not required.

Last Name	First Name	MI	Social Security #	Date of Birth	Gender	Other Insurance
					☐ M ☐ F	☐ Yes ☐ No
					☐ M ☐ F	☐ Yes ☐ No
					☐ M ☐ F	☐ Yes ☐ No
					☐ M ☐ F	☐ Yes ☐ No
					☐ M ☐ F	☐ Yes ☐ No
					☐ M ☐ F	☐ Yes ☐ No
					☐ M ☐ F	☐ Yes ☐ No
					☐ M ☐ F	☐ Yes ☐ No

BENEFIT PLAN OPTIONS		**COVERAGE LEVEL**
☐ BAC Health, Rx, Dental Vision Plan		☐ EMPLOYEE ONLY ☐ EMPLOYEE + SPOUSE ☐ FAMILY
Benefit Plan Waiver		

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☐ Group coverage sponsored by my spouse's employer
☐ other reasons (please explain):

☐ Group coverage sponsored by another organization
Please provide name of carrier and your policy number:

Beneficiary information
Please confirm the beneficiary for your life insurance benefit.
Please provide: Name, DOB, SSN, Address & Phone Number for your beneficiary.

Other Insurance
If you answered "Yes" above for you or any of your dependents complete this section. If more space is needed use the back of this form.

Name of covered individual:	Name of employer:	
Insurance Carrier:	Policy Number:	Is this plan Primary: ☐ Yes ☐ No
Address:	Phone Number:	

I hereby waive coverage in the Health Plan offered to me by my employer, I understand that I will not have an opportunity to enroll in the Group Health Plan until the next open enrollment period or unless I experience a Life Status changing event.

Employee Signature _____ Date

My signature below is confirmation that I have elected the Group Health Plan offered to me by my employer as indicated above. I understand that my contributions through payroll deduction are voluntary and in compliance with Federal Regulations and State Laws. I further understand that I cannot change my elections until the next open enrollment period or unless I experience a Life Status change. As Plan administrator, Insurance Administrator of America, Inc. is authorized to obtain necessary personal medical information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) in order to administer the Group Health Plan in which I participate.

Employee Signature _____ Date _____