

D. H. Evans Employees, Inc.

P. O. Box 6480

Harrisburg, PA 17112



**PLUMBERS & PIPEFITTERS LOCAL NO. 520  
HEALTH & WELFARE FUND**

**To Be Completed By Contract Administrator:**

**Change**

**Effective Date** \_\_\_\_\_

**Unix** \_\_\_\_\_

**Basys** \_\_\_\_\_

**ESI** \_\_\_\_\_

**NVA** \_\_\_\_\_

**Delta** \_\_\_\_\_

**PARTICIPANT INFORMATION:** (please complete all lines)

Name \_\_\_\_\_  
(Last) (First) (Middle) Date of Birth Social Security Number

Mailing Address \_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City) (State) (Zip)

**COMPLETE THIS SECTION WHEN ADDING OR REMOVING DEPENDENT(S).** (check reason and give date of change)

**MARRIAGE** – Date of Marriage \_\_\_\_\_ (Please include copy of Marriage Certificate/License)

Name \_\_\_\_\_  
(Last) (First) (Middle) Date of Birth Social Security Number

Is your new spouse employed?  Yes  No

If yes, name and address of spouse's employer: \_\_\_\_\_

Does your new spouse have medical coverage?  Yes  No

Does your new spouse have medical coverage for dependents?  Yes  No

Name and address of spouse's insurance company: \_\_\_\_\_ Policy Number or Group Number: \_\_\_\_\_

**DIVORCE** – Date of Divorce Decree \_\_\_\_\_ (Please include copy of Divorce Decree and former spouse's current mailing address)

**ADDITION OF CHILD**

Newborn – Date of Birth \_\_\_\_\_ (Please include copy of Birth Certificate)

Adoption - Effective Date \_\_\_\_\_ (Please include copy of Adoption paperwork)

Due to Marriage – Effective Date \_\_\_\_\_ (Please include copy of Birth Certificate)

Name	M/F	Date of Birth	Social Security	Add/Remove	Student? Yes/No
				<input type="checkbox"/> ADD	<input type="checkbox"/> YES
				<input type="checkbox"/> REMOVE	<input type="checkbox"/> NO
				<input type="checkbox"/> ADD	<input type="checkbox"/> YES
				<input type="checkbox"/> REMOVE	<input type="checkbox"/> NO
				<input type="checkbox"/> ADD	<input type="checkbox"/> YES
				<input type="checkbox"/> REMOVE	<input type="checkbox"/> NO
				<input type="checkbox"/> ADD	<input type="checkbox"/> YES
				<input type="checkbox"/> REMOVE	<input type="checkbox"/> NO

**DEPENDENT CHILD NO LONGER STUDENT** – Effective Date \_\_\_\_\_

**DECEASED** – Date of Death \_\_\_\_\_ (Please include copy of Death Certificate)

**CHANGE OF BENEFICIARY**

**DEATH BENEFIT AUTHORIZATION** (Please list your beneficiary and contingent beneficiary (optional) below):

**Beneficiary:** Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Relationship \_\_\_\_\_

**Contingent:** Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Relationship \_\_\_\_\_

I hereby authorize the Plan to make the changes requested above to my enrollment records. I understand the effective date of the changes will be determined by the Plan. I verify that the information given in this Enrollment Change Form is true and correct. I understand that false statements made herein or fraudulent claims made hereunder are subject to penalty under the Plan.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_