PLUMBING & PIPEFITTING INDUSTRY
HEALTH & WELFARE FUND OF KANSAS

CIGNA
GROUP#3339444

DELTA DENTAL PLAN OF KANSAS
GROUP# 90296

SUBSCRIBER INFORMATION UPDATE

To be able to pay your claims promptly and correctly, we must keep our records up-to-date. Please review your personal health coverage information below and complete the form as requested. Read each section closely. This is what we have in our files. If any item is incorrect or is incomplete, please furnish the proper information in the space provided. If there is not enough room in the Dependent information section for additional dependents, please list them along with the information requested on another piece of paper and attach it to this form.

PLEASE PRINT LEGIBLY. **MAIL TO** PPI H&W FUND OF KS, 505 S BROADWAY, STE 117, WICHITA, KS 67202-3922

GROUP:CIGNA 3339444/DELTA#90296 I.D.#:	ADDRESS CORRECTIONS:
NAME:	
ADDRESS:	
CITY,STATE,ZIP:	

NAME (first, middle init., last) (**LIST BELOW ALL FAMILY MEMBERS (INCLUDING UNION MEMBER) WHO ARE TO BE COVERED BY INSURANCE)**	SOCIAL SECURITY NO. (if available)	SEX	RELATIONSHIP TO SUBSCRIBER	BIRTH DATE MO - DAY - YR
		M	**SELF**	

COMPLETION OF THIS SECTION IS REQUIRED

COORDINATION OF BENEFITS

1. MARRIED ☐ SINGLE ☐
   a. IF MARRIED, IS YOUR SPOUSE EMPLOYED? YES ☐ NO ☐
   b. IF YES, NAME & ADDRESS OF EMPLOYER _____
2. ARE YOU, YOUR SPOUSE, OR YOUR DEPENDENT CHILDREN ENTITLED TO BENEFITS FROM ANY OTHER GROUP INSURANCE OR HMO, FOR HOSPITAL, SURGICAL, MEDICAL, OR DENTAL EXPENSE? YES ☐ NO ☐
   a. IF YES, NAME OF FAMILY MEMBER WITH OTHER GROUP INSURANCE? _____
   b. TYPE OF COVERAGE: SINGLE ☐ FAMILY ☐
   c. NAME OF GROUP INSURANCE CARRIER _____ I.D./POLICY # _____
3. DO YOU OR ANY OF YOUR LISTED DEPENDENTS HAVE MEDICARE PARTS A & B? YES ☐ NO ☐
   a. MEDICARE NUMBERS: HUSBAND _____ WIFE _____ DEPENDENDENT _____

*BY SIGNING BELOW, I REPRESENT THAT THIS INFORMATION IS CORRECT AS EITHER INDICATED ON THIS FORM OR AS CORRECTED BY MYSELF** (TO BE SIGNED BY UNION MEMBER IN INK!!!!)

SIGNATURE _____ DATE _____ 1-1-16

NOTE: FUTURE ADDITIONS OR CHANGES TO DEPENDENTS SHOULD BE COMMUNICATED THROUGH YOUR HEALTH & WELFARE FUND OFFICE BY CALLING (316) 264-2339 OR WRITING TO THE ADDRESS ABOVE.
FORMS ARE AVAILABLE FOR DOWNLOAD AT WWW.PPI-FUND.ORG