SUBSCRIBER INFORMATION UPDATE

To be able to pay your claims promptly and correctly, we must keep our records up-to-date. Please provide the information below, return this form, and STATE ISSUED birth certificate for dependent children, and/or marriage license for spouse, as requested. If there is not enough room in the Dependent information section for additional dependents, please list them along with the information requested on back side of this form.

In order to enroll a newborn dependent child for coverage retroactive to the child's date of birth **you must send the Fund office an updated copy of this Form and a state issued birth certificate for the child within 90 days after the child is born**. Otherwise, coverage for the child will be effective prospectively as of the date the Fund office has received both the updated form and the birth certificate.

EFFECTIVE DATE: _____ CONTACT NUMBER: _____

Group: **Aetna #: 169495 / Delta Dental of KS #: 90296**	**PLEASE PRINT LEGIBLY. MAIL TO:**
Name:	**Benefits Management Group, Inc. 441 Benefits Office**
Address:	**529 S. Anna Street, Ste B**
City, State, Zip:	**Wichita, KS 67209**

NAME: First, Middle, Last (List below ALL family members, including self, to be covered by insurance.)	**SOCIAL SECURITY NO.**	**SEX**	**RELATIONSHIP**	**BIRTH DATE**
			MEMBER	

COMPLETION OF THIS SECTION IS REQUIRED

1. MARRIED ☐ SINGLE ☐
   a. If married, is your spouse employed? YES ☐ NO ☐
   b. If yes, name and address of employer: _____
2. Are you, or any of your dependents, entitled to benefits from any other health and/or dental insurance? YES ☐ NO ☐
   a. If yes, name of family member with other insurance? _____
   b. Type of coverage: SINGLE ☐ FAMILY ☐
   c. Name of insurance carrier _____ I.D./Policy # _____

BY SIGNING BELOW, I REPRESENT THAT THE INFORMATION CONTAINED ON THIS FORM IS TRUE AND CORRECT. (TO BE SIGNED BY UNION MEMBER IN INK!!!!)

SIGNATURE _____ DATE _____

Future additions, or changes to dependents, or concerning your spouse's coverage under his/her employer's plan, must be communicated through your Health and Welfare Fund office by calling (316) 264-2339, or writing to the address above. Forms are available for download by logging in to BMGIWEB.COM/441