Dependent Consent Form

I consent to the use of and disclosure of my Protected Health Information for the purpose or healthcare treatment, claims payment and/or healthcare operations. I understand that I may revoke this consent and will submit a written request if I decide to do so. By signing this consent form I also agree that I have received a copy of the NECA Local No. 145 IBEW Welfare Plan Privacy Policies.

Dependent Name (please print)	Dependent Social Security Number
Dependent Signature	Date

DEPENDENT OF:

Participant Name (please print)	Participant Social Security Number

****FAILURE TO SIGN THIS CONSENT FORM PERMITS THE PLAN TO REFUSE YOUR ENROLLMENT AND/OR DENY HEALTH CLAIMS.****

Pin Number

To access your information you must have a pin number. Please fill in the section below with a four-digit numerical pin number. If you lose or forget this pin number you must contact the Fund Office. We will send a new request for pin number that must be completed and returned before you can access your account.

RETURN THIS FORM IMMEDIATELY TO THE FUND OFFICE

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