STEPCHILD INFORMATION SHEET

National Elevator Industry Health Benefit Plan
19 Campus Blvd, Ste 200
Newtown Square Pa 19073-3288

I, _____ do hereby attest that the following is/are my
Print member name

stepchild(ren):

_____	_____
Print stepchild name	Print stepchild name
_____	_____
Print stepchild name	Print stepchild name

The above named stepchild(ren): **(check one box below)**

- □ is/are **not** covered under another health plan.
- □ is/are covered under another health plan. (Complete section below.)

_____ _____
Other Health Plan Name Other Health Plan ID/Group #

_____
Name of Policy Holder for Other Health Plan

_____ _____
Members signature **Date**

_____
Member ID#:

*****You may fax this completed form to (610)325-9028 or mail to the address above****

ANY PERSON WHO FILES THIS FORM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND WILL BE RESPONSIBLE FOR REIMBURSING THE NEI HEALTH BENEFIT PLAN FOR CLAIMS THAT THE NEI HEALTH BENEFIT PLAN SHOULD NOT HAVE PAID FOR.