Pipe Fitters Local No. 533 Health and Welfare Plan

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ENROLLMENT FORM

Directions: Complete this Enrollment Form and return it to the Fund Office. **You must submit the following items to the Fund Office with this Enrollment Form, if you have not previously provided them to the Fund Office** (as applicable):
• If you are married and your spouse was employed on January 1, 2019, you must include the Employed Spouse Coverage Affidavit if your spouse is not already enrolled in Qualifying Health Coverage through his or her employer.
*If you or your Dependent(s) have other group medical coverage, you must include a photocopy of the front and back of the I.D. card for the other coverage.
• If you are married, you must include a copy of your Marriage Certificate.
• If you are enrolling a Dependent child(s), you must include a copy of the child's birth certificate, adoption papers, or court order for custody and support or maintenance (as applicable).

PIPE FITTER INFORMATION:

Pipe Fitter Name:	Social Security Number:
Date of Birth:	Phone Number:
Address:	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Do you have other health insurance? Yes ❑ No ❑ If Yes, please attach copy of other insurance ID card(s). If your other coverage is Medicare, please complete the backside of this form.

SPOUSE INFORMATION:

Make sure you fill out all of the information for your spouse.

Spouse's Name	Date of Birth	Social Security Number	Sex	Do you currently have other insurance?	Coverage Type
				Yes ☐ No ☐	☐ Medical/Rx ☐ Vision ☐ Dental

Was your Spouse employed on Jan 1, 2019? Yes ☐ No ☐ Self Employed on Jan 1, 2019? Yes ☐ No ☐

☐ **If the answer is Yes and your spouse is already enrolled in Qualifying Health Coverage through their employer, skip the next section and proceed to the Dependent Child Information section.**
☐ **If the answer is Yes and your spouse is NOT enrolled in Qualifying Health Coverage through their employer, you must complete the Employed Spouse Coverage Affidavit and complete the below section.**
If the answer is No, or (s)he was self-employed, skip the next section and proceed to the Dependent Child Information section.

Does your Employed Spouse Coverage Affidavit reflect your spouse is eligible for Qualifying Health Coverage as of March 31, 2019? (if this question is not applicable, proceed to the Dependent Child Information section)

☐ **Yes,** my spouse has Qualifying Health Coverage available from his/her employer as of March 31, 2019, **and my spouse will enroll** in such coverage by April 1, 2019. Please submit proof of enrollment, i.e.: copy of ID Card, completed enrollment form or letter from employer.
☐ **Yes,** my spouse has Qualifying Health Coverage available from his/her employer as of March 31, 2019, **but my spouse will not enroll** in such coverage by April 1, 2019. I understand that at 11:59 p.m. on March 31, 2019 my spouse will no longer have coverage from the Pipe Fitters Local No. 533 Health and Welfare Fund
☐ **No**, my employed spouse does not have Qualifying Health Coverage available from his/her employer as of March 31, 2019.

DEPENDENT CHILD INFORMATION:

Make sure you fill out all of the information for each Dependent child that is eligible for coverage from the Plan. **It is extremely important that you list each of your Dependent children that is under the age of 26.** If you have more than five eligible Dependent children, attach a separate sheet of paper to this Enrollment Form that includes information regarding those additional Dependent children.

Dependent's Name	Relationship	Date of Birth	Social Security Number	Sex	Do they have other insurance?	Coverage Type
					Yes ☐ No ☐	☐ Medical/Rx ☐ Vision ☐ Dental
					Yes ☐ No ☐	☐ Medical/Rx ☐ Vision ☐ Dental
					Yes ☐ No ☐	☐ Medical/Rx ☐ Vision ☐ Dental
					Yes ☐ No ☐	☐ Medical/Rx ☐ Vision ☐ Dental
					Yes ☐ No ☐	☐ Medical/Rx ☐ Vision ☐ Dental

(YOU MUST COMPLETE THE BACKSIDE OF THIS FORM)

***If your Spouse or your Dependent(s) have other group medical coverage, you must include a photocopy of the front and back of the I.D. card for the other coverage. If your other coverage is Medicare, please complete the below section of this form.**

The following is extremely important information. Please read this language carefully and then sign and date this Enrollment Form and return it to the Fund Office. If you are married, both you and your spouse must sign and date this Enrollment Form.

I hereby certify that all information on provided on this Enrollment Form is correct to the best of my knowledge. I understand that if this information changes, it is my responsibility to notify the Fund Office immediately. I also understand that I will be required to reimburse the Plan for any payments made as a result of my failure to notify the Fund Office of a change in the information provided on this Enrollment Form.

____

Participant's Signature ***Date of Signature***

____

Spouse's Signature ***Date of Signature***

Medicare Information Including Medicare Part D – Prescription Drug Program (If applicable, complete this section)

Your Name:_______________________________________Date of Birth______/_____/_____

Effective Date: Part A:______/_____/_____Part B:______/_____/_____Part D:______/_____/_____

Do you have Medicare due to End-stage renal disease? Yes ❑ No ❑ If Yes, Effective Date:______/_____/_____

Spouse's Name:_____________________________________Date of Birth______/_____/_____

Effective Date: Part A:______/_____/_____Part B:______/_____/_____Part D:______/_____/_____

Do you have Medicare due to End-stage renal disease? Yes ❑ No ❑ If Yes, Effective Date:______/_____/_____

Other's Name:_____________________________________Date of Birth______/_____/_____

Effective Date: Part A:______/_____/_____Part B:______/_____/_____Part D:______/_____/_____

Do you have Medicare due to End-stage renal disease? Yes ❑ No ❑ If Yes, Effective Date:______/_____/_____

Life-Changing Events

When you get married, provide the Fund Office with:
- A copy of your marriage certificate
- Your spouse's date of birth
- A copy of your spouse's medical insurance information, if he or she is covered under another plan

If you add a child, provide the Fund Office with:
- A copy of the child's birth certificate, adoption papers, or court order for custody and support or maintenance (as applicable)
- A copy of your child's other medical insurance information, if he or she is covered under another plan

If you get legally separated or divorced, provide the Fund Office with:
- A copy of your separation or divorce decree
- A copy of any QDRO
- If you have children for whom you do not have custody, a copy of any QMCSO

Life changing events are all subject to the terms of the Pipe Fitters Local No. 533 Health and Welfare Plan Document. If you have any questions regarding enrollment, please see your Summary Plan Description or contact the Fund Office.