I.B.U. of the Pacific National Health Benefit Trust

PARTICIPANT ENROLLMENT FORM

CHECK ALL THAT APPLY:

☐ **New Enrollment** ☐ **Adding Dependents** ☐ **Dropping Dependents** ☐ **Plan Change** ☐ **Address Change**

EMPLOYEE'S FULL LEGAL NAME:_____ SSN: _____

ADDRESS:_____ CITY: _____

STATE: _____ ZIP: _____ PHONE NUMBER: (_____) _____

EMAIL:_____ DATE OF BIRTH:_____ GENDER: (Circle One) ☐ Male ☐ Female

MARITAL STATUS: ☐Married (Date of Marriage)_____ ☐Single ☐Divorced (Date of Divorce) _____

☐Domestic Partner (Date of Domestic Partnership)_____ ☐ Domestic Partnership Dissolution (Date of dissolution) _____

DATE OF HIRE:_____ EVENT DATE:_____ EFFECTIVE DATE:_____

MEDICAL/PRESCRIPTION, DENTAL, AND VISION PLAN:

PREMERA BLUECROSS BLUESHIELD OF WASHINGTON/ALASKA PPO NETWORK
MODA (ODS) – PRESCRIPTION
DENTAL THROUGH IBU TRUST – MAY USE ANY PROVIDERS
VISION - VSP

NOTE: IF YOU, YOUR SPOUSE, YOUR DOMESTIC PARTNER, OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE OR MEDICARE ELIGIBLE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

DEPENDENTS - (Including Spouse/Domestic Partner)

ATTACH LEGAL DOCUMENTATION THAT APPLIES FOR EACH DEPENDENT YOU ARE ENROLLING:
(Birth certificate(s) for children, Marriage Certificate, Legal Adoption/ Legal Guardianship papers, Divorce papers)

REMOVE	ADD	FULL NAME	SSN	DATE OF BIRTH	GENDER	RELATIONSHIP
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					

I agree to notify the Trust Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

MEMBER'S SIGNATURE:_____ **DATE:** _____

PMB #116 · 5331 S Macadam Avenue Suite 258, · Portland, OR 97239
(503) 224-0048 (800) 547-4457 Fax (503) 228-0149 ibu@benesys.com
www.ibubenefits.org

Coordination of Benefits

☐ **If you and/or your dependents DO NOT have any other insurance coverage, please check this box and sign/date at the bottom of the page under "Member Statement" (section E)**

Member Information: Name: _____ SSN or ID: _____

Other Insured Person (Policy Holder):

Name:_____Date of Birth:_____Relationship to Member: _____

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS INCLAIMS PROCESSING

OTHER HEALTH COVERAGE INFORMATION

A Does this plan include **Medical** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO
Name of Medical Carrier:_____Phone#:_____
Effective Date:_____Policy/Group Number:_____

B Does this plan include **Dental** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO
Name of Dental Carrier:_____Phone#:_____
Effective Date:_____Policy/Group Number:_____

C Does this plan include **Vision** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO
Name of Vision Carrier:_____Phone#:_____
Effective Date:_____Policy/Group Number:_____

D Does this plan include **Prescription** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO
Name of Prescription Carrier:_____Phone#:_____
Effective Date:_____Policy/Group Number:_____

Fill out this section only if your children have health care coverage in addition to the above because of divorce, separation, court order or marriage work related group coverage.

Is there a court order that determines responsibility for health care coverage or custody? □Yes or □ No

If yes, attach a copy of the sections that apply to health care responsibility and/or custody arrangements

Name of person responsible for child's heath care coverage?		Employer	Birthdate
Insurance company name	Insurance company city	State	Phone number
Enrollee ID/policy number	Group number	Effective date	Cancellation date (if applicable)

List all covered dependents:

1._____ Social Security# ---------- _____
2._____ Social Security# ---------- _____
3._____ Social Security# ---------- _____
4._____ Social Security# ---------- _____
5._____ Social Security# ---------- _____

Custody Insurance: 1. Are you divorced or separated from the parent of any dependent on this policy listed above? □Yes or □ No

- If Yes (continue) If No (skip to section E) ***(Indicate which child by marking appropriate circle)***

2. Does one parent/guardian have full custody of the child(ren)? □Yes or ■ No (If yes, which child)? ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6
   - Parent:_____ Date: _____
3. Is one parent required by court decree to provide health insurance for the children? □Yes or ■ No ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6
   - Parent:_____ Date: _____

****If court decree is present, please provide an ATTACHMENT to the back of this copy****

Medicare/Medicaid (if applicable)	Are you or anyone else on your policy covered by Medicare or Medicaid? □Yes or □ No	Medicare Policy holder name	Medicare HIC number
Is the covered person retired? □Yes or □ No		Is the Medicare coverage because of? □Age or □ Disability	

****** Medicare coverage includes: (check all that apply, followed by effective date) ******

Type: A □ B □ C □ D □ Effective date: A)_____B)_____C)_____D)_____

Member Statement: The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage. Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

E	**Signature**		Telephone Number:	Date: