

Northern California Tile Industry Trust Funds

Health & Welfare • Vacation & Holiday • Defined Benefit Pension • Defined Contribution Pension



VITAL INFORMATION FORM

CHECK ALL THAT APPLY: **New Enrollment** **Adding Dependents** **Plan Change** **Address Change**

EMPLOYEE'S FULL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ DATE OF BIRTH: _____

PHONE NUMBER: (_____) _____ GENDER: (Circle One) Male Female

<u>MEDICAL PLAN (CHOOSE ONE):</u> <input type="checkbox"/> SELF-FUNDED PPO PLAN (INDEMNITY PLAN) <input type="checkbox"/> KAISER <input type="checkbox"/> UNITED HEALTHCARE HMO	<u>DENTAL:</u> SELF-FUNDED PPO PLAN <u>VISION:</u> VISION SERVICE PLAN
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Medicare Claim Number: (including the letter(s) that follows the number)

(Applicable only when a member, a spouse, or a covered dependent is age 65 or older; or is on Medicare disability.)

Member # _____ Spouse # _____ Dependent# and Name _____

DEPENDENTS - (Including Spouse)

Include additional dependents on desperate page

I agree to notify the Fund 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 stating false or misleading information or the omission of material information could be grounds for denial of benefits.

DATE: _____ **MEMBER SIGNATURE** _____

7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566

P.O. Box 1607 San Ramon, CA 94583

Phone 925.208.9995 • Toll Free 888.208.0250 • Facsimile 925.462-0108

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 IN CLAIMS PROCESSING

OTHER HEALTH COVERAGE INFORMATION

A	Does this plan include <u>Medical</u> Coverage? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, is this plan an: <input type="checkbox"/> HMO or <input type="checkbox"/> PPO Name of Medical Carrier: _____ Phone#: _____ Effective Date: _____ Policy/Group Number: _____
B	Does this plan include <u>Dental</u> Coverage? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, is this plan an: <input type="checkbox"/> HMO or <input type="checkbox"/> PPO Name of Dental Carrier: _____ Phone#: _____ Effective Date: _____ Policy/Group Number: _____
C	Does this plan include <u>Vision</u> Coverage? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, is this plan an: <input type="checkbox"/> HMO or <input type="checkbox"/> PPO Name of Vision Carrier: _____ Phone#: _____ Effective Date: _____ Policy/Group Number: _____
D	Does this plan include <u>Prescription</u> Coverage? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, is this plan an: <input type="checkbox"/> HMO or <input type="checkbox"/> 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 health 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? <input type="checkbox"/> Yes or <input type="checkbox"/> No	Medicare Policy holder name	Medicare HIC number
Is the covered person retired? <input type="checkbox"/> Yes or <input type="checkbox"/> No		Is the Medicare coverage because of? <input type="checkbox"/> Age or <input type="checkbox"/> 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:
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