# IDAHO PIPE TRADES TRUST (IPTT) HEALTH & WELFARE PLAN (Plan)

**PMB #116, 5331 S Macadam Avenue Suite 258, Portland OR 97239**
**www.iptt.org 208-288-1610 or 800-808-1687 Fax 208-288-1670 iptt@benesys.com**

## HEALTH & WELFARE PLAN ANNUAL ENROLLMENT EFFECTIVE JANUARY 1, 2026

**ALL PARTICIPANTS WITH DEPENDENTS MUST COMPLETE AND RETURN THIS FORM PROMPTLY TO IPTT NO LATER THAN NOVEMBER 14, 2025.**

**Participant's Name** **Social Security Number (SSN)** **Address *(notify IPTT if your address changes)*** **Phone #**

☐ **NO CHANGES** from Dependents covered in 2025 to Dependents covered in 2026 (refer to Dependents listed on enclosed letter) **or if you have no Dependents**. **If NO CHANGES, stop here – read, sign and date back of form and send to IPTT no later than November 14, 2025.**

**OR**

☐ **YES, CHANGES or ADDITIONS (to Dependents listed on enclosed letter):** complete form with ALL Eligible Dependents you want covered in 2026. Return this form and copies of marriage & birth certificates (if you haven't previously done so) to IPTT no later than November 14, 2025. Please provide marriage and/or birth certificates in order to enroll your Spouse and/or Dependents.

☐ Add ☐ Change ☐ Remove

1. First Name | Last Name | Birth Date | SSN (required) | **Covered by any other Insurance plan (not IPTT)?** Check all other coverages that apply: Medical/Rx | Dental | Vision | Policyholder Name & Birth date

Is the other coverage through this Dependent's employer? Yes ☐ No ☐

Address (if different from yours): _____

Phone Number

Individual's relationship to you: _____

☐ Add ☐ Change ☐ Remove

2. First Name | Last Name | Birth Date | SSN (required) | **Covered by any other Insurance plan (not IPTT)?** Check all other coverages that apply: Medical/Rx | Dental | Vision | Policyholder Name & Birth date

Is the other coverage through this Dependent's employer? Yes ☐ No ☐

Address (if different from yours): _____

Phone Number

Individual's relationship to you: _____

**(O V E R – SIGNATURES REQUIRED ON BACK OF FORM)**

☐ Add ☐ Change ☐ Remove

3. First Name | Last Name | Birth Date | SSN (required) | **Covered by any other Insurance plan (not IPTT)?** Check all other coverages that apply: Medical/Rx | Dental | Vision | Policyholder Name & Birth date

Is the other coverage through this Dependent's employer? Yes □ No □

Address (if different from yours): _____

Phone Number

Individual's relationship to you: _____

☐ Add ☐ Change ☐ Remove

4. First Name | Last Name | Birth Date | SSN (required) | **Covered by any other Insurance plan (not IPTT)?** Check all other coverages that apply: Medical/Rx | Dental | Vision | Policyholder Name & Birth date

Is the other coverage through this Dependent's employer? Yes □ No □

Address (if different from yours): _____

Phone Number

Individual's relationship to you: _____

☐ Add ☐ Change ☐ Remove

5. First Name | Last Name | Birth Date | SSN (required) | **Covered by any other Insurance plan (not IPTT)?** Check all other coverages that apply: Medical/Rx | Dental | Vision | Policyholder Name & Birth date

Is the other coverage through this Dependent's employer? Yes □ No □

Address (if different from yours): _____

Phone Number

Individual's relationship to you: _____

♠ **VERY IMPORTANT – PLEASE READ:**

♠ If your Spouse works at least 20 hours per week or 80 hours per month and has group insurance coverage available through an employer but does not elect that coverage, your Spouse is not an Eligible Dependent and the Plan will not cover your Spouse's claims for benefits under the Plan. This applies whether or not your Spouse must pay for the other coverage. See page 9 of the SPD.

♠ **NOTIFYING THE PLAN OF OTHER COVERAGE AND ELIGIBILITY CHANGES:** If you or your Spouse or Dependents become eligible for and/or enrolled in or lose other group health coverage, and/or your Spouse or Dependents no longer qualify as an Eligible Dependent (for example, if you and your Spouse have divorced), you are required to notify IPTT in writing within 60 days of the change by completing a Health & Welfare Plan Change Form. Failure to do so and/or any false statements or misrepresentations on this form is considered fraudulent, may result in retroactively terminating plan coverage, and you and/or your Dependents will be responsible for reimbursement of all amounts paid in connection with such coverage. See pages 46-47 of the SPD.

♠ **DECLARATION AND ACKNOWLEDGEMENT:** I have provided the above information to the very best of my knowledge and confirm that any Dependents I am requesting coverage for are Eligible Dependents. I declare under penalty of perjury under the laws of the United States of America that **the information herein is true and correct**. I understand Section 1027 of Title 18 of the United States Code makes it a crime to knowingly make a false statement in any document required to be kept by the Plan or certified to the Plan Administrator, and that the punishment for violation of this law can be a fine up to the greater of $250,000 or twice the gross pecuniary gain or loss, and imprisonment for as long as five years. I understand and acknowledge that in order to process claims for benefits, physicians, hospitals or other medical providers may share information with Idaho Pipe Trades Health & Welfare Trust or their representatives regarding my or my Dependents' health history, symptoms, treatment, examination results or diagnosis.

**THIS FORM MUST BE RETURNED TO IPTT DURING THE MONTHS OF OCTOBER OR NOVEMBER AND NO LATER THAN NOVEMBER 14, 2025.**

_____ _____ _____ _____

Participant's Signature (required) | Date | Spouse's Signature (required) | Date

_____ _____ _____ _____

Participant's Printed Name (required) | Date | Spouse's Printed Name (required) | Date