IDAHO PIPE TRADES TRUST

Administrative Office

Idaho Pipe Trades
Health & Welfare Trust
LU 296 & LU 648

Plumbers & Pipefitters
Pension Trust
LU 296 LU 648 LU 41

HEALTH & WELFARE PLAN ENROLLMENT FORM

Due Within 120 DAYS of when you are first eligible or of a qualified status change event date

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

EMPLOYEE'S FULL LEGAL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ LOCAL UNION NO. _____

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

CELL PHONE NUMBER: (_____) _____ **HOME PHONE NUMBER:** (_____) _____

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

MEDICAL/PRESCRIPTION, DENTAL, AND VISION PLAN:

MEDICAL, DENTAL & VISION - BLUECROSS OF IDAHO (Group# 10034808)
PRESCRIPTION – Express Scripts (ESI) (Group# IDAPITT)

NOTE: If you, your spouse, or any of your dependents are on Medicare or Medicare Eligible, please include a copy of your Medicare Card.

IMPORTANT: 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 will not be considered 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 SPD Pages 9-11.)

NOTIFYING THE PLAN OF OTHER COVERAGE CHANGES: If you or your spouse or dependents become eligible for and/or enrolled in or loses other group health coverage you are required to notify IPTT in writing within 120 days by completing a Health & Welfare Plan Change Form. Failure to notify IPTT of other coverage changes and/or any false statements or misrepresentation on this form is considered fraudulent and may result in retroactively terminating plan coverage and you will be responsible for reimbursement for all amounts paid in connection with such coverage. See page 46 of the SPD.

DEPENDENTS - (Including Spouse)

YOU MUST ATTACH LEGAL DOCUMENTATION THAT APPLIES TO ADD YOUR DEPENDENTS:

Birth Certificate(s) for children, Marriage Certificate for spouse, Legal Adoption papers, Legal Guardianship papers

OTHER COVERAGE	FULL NAME	RELATIONSHIP	DATE OF BIRTH	SSN	GENDER
Yes ☐ No ☐					
Yes ☐ No ☐					
Yes ☐ No ☐					
Yes ☐ No ☐					
Yes ☐ No ☐					

DECLARATION: I have provided the above information to the very best of my knowledge. I declare under penalty of perjury under the laws of the United States of America **that the foregoing 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 or certified to the administrator of a pension or health/welfare plan. I further understand that the punishment for violation of this law can be both a fine up to $10,000 and imprisonment for as long as five years.

ACKNOWLEDGMENT: 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 me or my dependents' health history, symptoms, treatment, examination results or diagnosis.

EMPLOYEE SIGNATURE _____ **DATE** _____

SPOUSE SIGNATURE _____ **DATE** _____

PMB #116 · 5331 S Macadam Avenue Suite 258, · Portland, OR 97239
Telephone (800) 808-1687 or (208) 288-1610 FAX (208)288-1670
Website: www.iptt.org Email: iptt@benesys.com

Coordination of Benefits

Member's Name: _____ Member ID #: _____ Date of Birth: _____

Address: _____

☐ ***If you and/or spouse/dependents DO NOT have any other insurance coverage, please check this box turn over and sign/date the bottom of the next page (under "Member Statement").***

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

A

MEMBER HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Medical Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Dental Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Vision Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

B

SPOUSE AND DEPENDENTS HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Medical Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Dental Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Vision Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

1.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

2.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

Continuation on other Side

For additional dependents, ATTACH A SEPARATE sheet with employee's name at top. (Last, First, MI)

3.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

4.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

C

FILL OUT THIS SECTION ONLY IF YOUR CHILD(REN) HAVE ADDITIONAL HEALTHCARE COVERAGE DUE TO •DIVORCE •SEPARATION •COURT ORDER •MEDICARE OR •OTHER FEDERAL-STATE HEALTH INSURANCE PROGRAMS.

*****(Indicate which child by marking appropriate circle) *****

1.) Is child(ren) covered by Medicare or other Federal-State coverage? □ Yes or □ No (If yes which child)? ○1 ○ 2 ○ 3 ○ 4

Medicare: Policyholder name: _____ Policy Number: _____
Is coverage because of? □ Age □ Disability □ ESRD
Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

Medi-Cal/Medicaid: Policyholder name: _____ Policy Number: _____

2.) Does one parent/guardian have full custody of the child(ren): □ Yes or □ No (If yes which child)? ○1 ○ 2 ○ 3 ○ 4

Parent: _____ **Date:** _____

3.) Is one parent required by court decree to provide health insurance for child(ren): □ Yes or □ No ○1 ○ 2 ○ 3 ○ 4

Parent: _____ **Date:** _____

Name of person responsible for child's healthcare coverage? _____
Employer: _____ Date of Birth: _____
Insurance Company name: _____ Insurance Company City & State: _____
Insurance Company Phone Number: _____ Enrollee ID/ policy number: _____
Group Number: _____ Effective date: _____ Cancellation date (if applicable): _____

******If court decree is present please PROVIDE A COPY of the court documents ******

Member Statement: The above information is true and accurate to the best of my knowledge and belief. I am also 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 because of such material in any matter.

Signature: _____ **Phone #:** _____ **Date:** _____