

IDAHO PIPE TRADES TRUST (IPTT) H&W PLAN

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HEALTH & WELFARE PLAN CHANGE FORM

- Use this form to:
- change** your address or a dependent's address OR **add** a new address for a dependent.
 - add** other Insurance coverage for a dependent (list Effective Date of other Insurance coverage).
 - take away** other Insurance coverage for a dependent. **IPTT must receive a copy of the Creditable Coverage Certificate (CCC)** from the other Insurance company showing the dates the dependent was covered (start date & end date) before IPTT can provide primary coverage.

Participant's Name	Birth Date	Social Security (SSN)	NEW Address	NEW Phone Number

- List dependents:**
- with a **NEW** address (if different from yours) OR
 - **adding** other Insurance coverage (list Effective Date of other Insurance) OR
 - taking away** other Insurance coverage (list End Date of other Insurance)

Add Change Remove

Covered by any other Insurance plan (not IPTT)?

Check all that apply: |

1.	First Name	Last Name	Birth Date	SSN (required)	Medical/Rx	Dental	Vision	Policyholder Name & Birth date

Is the other insurance through this dependent's employer? Yes No

NEW Address (if different from yours): _____

Individual's relationship to you: _____

Phone Number _____

Add Change Remove

Covered by any other Insurance plan (not IPTT)?

Check all that apply: |

2.	First Name	Last Name	Birth Date	SSN (required)	Medical/Rx	Dental	Vision	Policyholder Name & Birth date

Is the other insurance through this dependent's employer? Yes No

NEW Address (if different from yours): _____

Individual's relationship to you: _____

Phone Number _____

Add Change Remove

Covered by any other Insurance plan (not IPTT)?

Check all that apply: |

3.	First Name	Last Name	Birth Date	SSN (required)	Medical/Rx	Dental	Vision	Policyholder Name & Birth date

Is the other insurance through this dependent's employer? Yes No

NEW Address (if different from yours): _____

Individual's relationship to you: _____

Phone Number _____

O V E R – SIGNATURES REQUIRED ON BACK OF FORM

