THE EMPLOYEE PAINTERS' TRUST
HEALTH & WELFARE FUND

VITAL INFORMATION FORM

MEMBER Information: *(Please Print)*

Last: _____ First: _____ Middle: _____

Address/City/State/Zip: _____

Social Security Number: _____-_____-_____ Telephone Number: (_____) _____

Date of Birth: _____/_____/_____ Gender: (*circle one*) Male Female

Marital Status: *(circle one)* Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: _____

Current Status: *(circle one)* Active Retired Disabled COBRA

Email Address: _____ Alternate Phone Number: _____

Employer_____ Date of Hire: _____ Local Union #_____

Medicare Claim Number: (including the letter(s) that follows the number)
(This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)

Member # _____ Spouse # _____ Dependent # and Name _____

DEPENDENTS: - Include Spouse (If additional space is needed, please use 2nd sheet)

FULL NAME	RELATION	BIRTH-DATE	SOCIAL SECURITY NUMBER

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.

_____ _____

MEMBER SIGNATURE **DATE** **(OVER)**

5200 Southcenter Blvd., Suite 205, Tukwila, WA 98188 • P O Box 58830 • Tukwila, WA 98138
Phone (206) 518-9730 • Toll Free (844) 344-2721 • Fax (425) 251-1976
www.IUPATWesternBenefits.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 IN CLAIMS 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: