

Local Union No. 598 Plumbing & Pipefitting Health & Welfare Plan & Trust

PMB #116, 5331 S MACADAM AVENUE, SUITE 258, PORTLAND, OR 97239 1-800-205-7002 www.ua598benefits.org

IMPORTANT: THE INFORMATION ON THIS FORM WILL REPLACE ANY PREVIOUS ENROLLMENT INFORMATION SUBMITTED BY YOU.

Reason for Completing this Form (Please read back before continuing and check all that apply):

☐ New Participant:

Hire Date: _____

Employer: _____

☐ Adding Dependent(s):

Marriage*: _____ Date of Marriage _____

Birth*: _____ Date of Birth _____

Legal Adoption* _____ Date of Adoption _____

Other: _____

***INCLUDE MARRIAGE, BIRTH CERTIFICATE OR ADOPTION PAPERS**

☐ Removing Dependent(s):

Divorce**: _____ Date of Divorce _____

Death**: _____ Date of Death _____

Remove Child (circle one): Over-age or Eligible for other coverage

****INCLUDE DIVORCE OR DEATH CERTIFICATE**

☐ Change Of:

☐ Address

☐ Name

☐ Beneficiary

IMPORTANT PLEASE NOTE THE FOLLOWING:

Please list or re-list all eligible dependents, be sure to sign and date this form, and please mail completed form to The Trust Office's address listed on top of the form.

PARTICIPANT'S NAME (Last, First, Initial)		GENDER F <input type="checkbox"/> M <input type="checkbox"/>	DATE OF BIRTH (MM/DD/YYYY)
PARTICIPANT'S SOCIAL SECURITY NUMBER	EMAIL ADDRESS		
PARTICIPANT'S MAILING ADDRESS (Street, City, State, Zip)			MOBILE PHONE NUMBER ()
MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			HOME PHONE NUMBER ()
Date of Marriage: _____		Date of Divorce or Death of Spouse: _____	

ENROLLMENT FOR DEPENDENTS

Please see back of form for determining who is an eligible dependent

Add	Term	Relationship	Social Security Number	Full, Legal Last Name	Full, Legal First Name	MI	Date of Birth MM/DD/YYYY	GENDER M/F
		Spouse						
		Dependent						
		Dependent						
		Dependent						
		Dependent						

☐ Please check box to indicate if an additional page was needed to list additional dependents

Please specify the relationship to you of any dependent above whose last name is different than yours. _____

Other Current Coverage

Do you or any family members currently have other group (employer) coverage?

☐ Yes ☐ No

Are any dependents eligible (whether or not they are enrolled) for other group (employer) coverage through either their own or their spouse's employment?

☐ Yes ☐ No

If yes, dependent name and date dependent was first eligible for such coverage: _____

Are you or any family members covered by Medicare?

☐ Yes ☐ No

Are you or any family member covered by Medicare disability?

☐ Yes ☐ No

If the answer to any of the above questions is "Yes", complete the section below. (If you have more than one additional policy, provide information on a separate sheet.)

☐ Please check box to indicate if additional page was needed to list other coverage information.

Name of Policy holder with other coverage		Relationship		
Policy holder's birth date	Name of other group insurance Plan			
Address of other coverage		City	State	Zip
This coverage is for: <input type="checkbox"/> Medical <input type="checkbox"/> RX <input type="checkbox"/> Dental <input type="checkbox"/> Vision		Plan covers: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Stepchild(ren)		Numbers that identify you to other group Plan (group, ID, etc.):
Name of Employer:	<input type="checkbox"/> Continuation <input type="checkbox"/> Retiree <input type="checkbox"/> Active	Effective Date		Termination Date

Note: If you or your dependents become eligible for and/or enrolled in other coverage, you are required to notify the Plan in writing within 30 days. Failure to notify the Plan of other coverage may delay claims processing and/or result in overpayments for which the Trust will seek reimbursement from you. Any false statements or misrepresentation on this form is considered fraudulent and may result in rescission of coverage and you will be responsible for reimbursement for all amounts paid in connection with coverage provided based on fraud, including claims incurred.

BENEFICIARY INFORMATION: FOR PARTICIPANT LIFE AND ACCIDENTAL DEATH INSURANCE		
PRIMARY: Name (Last, First, Initial)	Social Security Number	Relationship
SECONDARY: Name (Last, First, Initial)	Social Security Number	Relationship
<input type="checkbox"/> Please check box to indicate if an additional page was needed to list additional beneficiaries <i>Be sure to name a beneficiary for your life insurance. If you are divorced, the spouse you named as the beneficiary will automatically be eliminated as the beneficiary, unless you complete a new enrollment form after the divorce and designate your former spouse as the beneficiary.</i>		
<p>I HEREBY APPLY FOR ENROLLMENT UNDER THE LOCAL 598 PLUMBING & PIPEFITTING INDUSTRY HEALTH & WELFARE PLAN & TRUST</p> <p>I hereby authorize any medical care institution or medical provider to give the Local 598 Plumbing & Pipefitting Industry Trust Funds or insuring carrier any information related to the physical or mental condition, medical history or medical treatment of me or my family members if the underwriting of my application or in administering claims under my policy. This authorization will remain valid so long as I remain eligible for benefits hereunder. To the best of my knowledge the above is complete and true, and I understand that falsification by me will allow the Local 598 Plumbing & Pipefitting Industry Trust Funds or insuring carrier to recover payments made, cancel my membership, and/or refuse to pay claims.</p>		
Participant Signature		Date

ENROLLMENT PROCEDURE FOR DEPENDENTS

Your legal spouse (You do not have a legal spouse if there is a divorce or legal separation)

Your dependent child from birth to age 26 is Your:

- a) Natural or adopted child
- b) Stepchild
- c) A child placed in Your home for the purpose of adoption and for whom You have assumed financial responsibility. A child placed in Your home for the purpose of adoption means the assumption and retention by You or a legal obligation of total or partial support of such person in anticipation of adoption;
- d) A child for whom You are required to provide health coverage pursuant to a qualified medical child support order;
and
- e) Foster child who is placed with You by an authorized agency or by judgment, decree, or order of any court of competent jurisdiction.

INCAPACITATED CHILD

A Dependent Child who is incapable of self-sustaining employment because of developmental disability or physical handicap, whose disability began while You were covered under this Plan or a predecessor plan sponsored by the Trustees and who qualifies as your dependent under Section 105(b) of the Internal Revenue Code will not have medical, dental and vision coverage terminated solely because he or she has reached the age limit for a Dependent Child if satisfactory documentation that the child is incapable of self-sustaining employment and is your dependent under Section 105(b) of the Internal Revenue Code is provided to the Plan Administrator before the child's 26th birthday and at reasonable intervals thereafter.

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