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

PMB #116, 5331 S MACADAM AVENUE, SUITE 258, PORTLAND, OR 97239 - Toll Free 1-800-205-7002 www.UA598benefits.org

ENROLLMENT APPLICATION FOR MEDICARE DENTAL AND VISION RETIREE COVERAGE

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 Retiree:**

Retirement Date:_____

Name of Pension Plan:_____

❑ **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_____

****INCLUDE DIVORCE OR DEATH CERTIFICATE**

Plan Election:

- ❑ HRA, Dental, & Vision
- ❑ HRA, & Dental only
- ❑ HRA, & Vision only
- ❑ HRA only

Payment Election:

- ❑ Deduct from Pension
- ❑ Deduct from HRA Account
- ❑ Deduct from Bank Account
- ❑ By Check or Money Order

*****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 ☐ M ☐	**DATE OF BIRTH** (MM/DDYYYY)
PARTICIPANT'S SOCIAL SECURITY NUMBER	**EMAIL ADDRESS**	
PARTICIPANT'S MAILING ADDRESS (Street, City, State, Zip)		**DAY PHONE NUMBER** ( )
MARITAL STATUS: ☐ **Married** ☐ **Never Married** ☐ **Divorced** ☐ **Widowed** **Date of Marriage:** **Date of Divorce or Death of Spouse:**		**EVENING PHONE NUMBER** ( )

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 MO/DA/YR	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 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 following section.
(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: □ Medical □ RX □ Dental □ Vision	Plan covers: □ Self □ Spouse □ Child(ren) □ Stepchild(ren)	Numbers that identify you to other group Plan (group, ID, etc.):		
Name of Employer:	□ Continuation □ Retiree □ 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 INSURANCE		
PRIMARY: **Name (Last, First, Initial)**	**Social Security Number**	**Relationship**
SECONDARY: **Name (Last, First, Initial)**	**Social Security Number**	**Relationship**

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

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 HEREBY APPLY FOR ENROLLMENT UNDER THE LOCAL 598 PLUMBING & PIPEFTTING INDUSTRY HEALTH & WELFARE PLAN & TRUST

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.

PARTICIPANT'S 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.

INCAPACTITATED 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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