RHODE ISLAND CARPENTERS BENEFIT FUNDS

NEW MEMBER ENROLLMENT FORM

MEMBER Information: *(Please Print)*

Last: _____ First: _____ Middle: _____

Address/City/State/Zip:_____

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

Email Address: _____ Alternate Phone Number: _____

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

Marital Status: (*circle one*) Single Married Divorced Separated Widowed
Date of Marriage/Divorce/Separation: _____

Type of Coverage Requested: *(circle one)* Individual Family Plan A Plan B

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

The information supplied on this form is true and complete. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payments directly to Tufts Health Plan providers for services rendered to me (us.) I grant Tufts Health Plan any legal right that I (we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the Tufts Health Plan member services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents. 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)

14 Jefferson Park Road • Warwick, RI 02888
Phone (401) 467-6813 • Fax (401) 467-6816

OTHER INSURANCE INQUIRY

Signature Required Below

Please complete this portion of the form if you, your spouse, or any of your dependents have other insurance coverage that you participate in, or if there has been any change in other insurance coverage.

General Information:

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Other Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Phone #: (_____)_____

Policy/Group Number: _____

Effective date of coverage: _____ Is insurance active? _____

Termination date if applicable: _____

Coverage is: (*circle one*) Single Family

Children are covered until age: _____

Type of coverage: (*circle all that apply*) Medical Dental Vision Prescription

List covered dependents: _____

_____

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 Benefit 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 contain 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.

I Have No Other Insurance: _____

Initial Here/Sign Below

_____ _____

Member Signature:_____ Date: _____