TEAMSTERS LOCAL 639 – EMPLOYERS HEALTH FUND

PO Box 99489
Troy, MI 48098-9998

(202) 636-8181
(800) 983-2699 - Phone
(202) 526-7959 – Fax

ENROLLMENT APPLICATION

To be completed by MEMBER (please print clearly, except for Signature)

Member' Name: _____ _____ _____
LAST **FIRST** **M.I.**

Member's Date of Birth _____ **Member's Social Security Number:** _____

Gender: ___ Male ___ Female **Marital Status:** ___ Single ___ Married* ___ Separated ___ Divorced*
Please attach a copy of marriage certificate or divorce decree

Address: _____
Street

_____ _____ _____
CITY **STATE** **ZIP CODE**

Home Phone: (_____) _____ **Mobile Phone:** (_____) _____

E-mail Address: _____ **Present Employer:** _____

BENEFICIARY (for Life Insurance and AD&D Benefits)

Primary Beneficiary
Name: _____
Last **First** **MI**

Address: _____
Street

_____
City **State** **Zip**

Relationship to Member: _____

Date of Birth: _____

Contingent* Beneficiary
Name: _____
Last **First** **MI**

Address: _____
Street

_____
City **State** **Zip**

Relationship to Member: _____

Date of Birth: _____

**If you die and your primary beneficiary is deceased your contingent beneficiary will receive your benefit.*
If you wish to divide your benefits among several persons, you need to fill out a separate form indicating the names, addresses and dates of birth, relationship to you and the percentage each person is to receive,

Dependents (refer to the page 2 and/or the Summary Plan Description for definition of dependent)
If dependent children, please attach a copy of the birth certificate.

Name	Relationship to Member	Date of Birth	Social Security Number
_____	Spouse	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Member's Signature: _____ **Date:** _____

Coordination of Benefits Form

Section 1 – Coordination of Benefits

Do you or any of your dependents have coverage under *any* group health plan (Medicare, employer sponsored health coverage, school insurance, etc.) other than the Fund?

_____ **Yes** Please complete *all four* sections and then return this form to the Fund's address noted above.

_____ **No** Please complete section 2 and then return this form to the Fund's address noted above.

Section 2 – Member Certification (To be Completed By All Members)

I hereby certify that the information on this form is true and correct and agree to notify and inform the Fund of any changes.

Member Name: _____ Social Security Number: _____

Date of Birth: _____ Phone Number: _____

Are you retired? ____ No ____ Yes Date of Retirement? _____

Signature: _____ Date: _____

Section 3 – Other Health Plan Coverage Information

Please provide this information for each group health care plan, other than Medicare, covering either you or your dependents.

Health Plan Information

Subscriber's Name: _____ Social Security Number: _____

Date of Birth: _____ This is an: ❑Active Policy ❑Retiree Plan ❑COBRA Plan

Covered Persons: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Company's Phone Number: _____ Effective Date: _____

Policy Number: _____ Group/Plan Number: _____

Section 4 – Medicare Coverage Information

Please provide this information for each individual on your policy covered by Medicare. Please write N/A or none if this section does not apply to anyone on your policy.

Name: _____ Medicare ID Number: _____

Effective Date: _____ Part A (Hospital) Reason Eligible: ____ Age
_____ Part B (Medical) ____ Disability
_____ Part D (Drug) ____ End Stage Renal Disease

Name: _____ Medicare ID Number: _____

Effective Date: _____ Part A (Hospital) Reason Eligible: ____ Age
_____ Part B (Medical) ____ Disability
_____ Part D (Drug) ____ End Stage Renal Disease

Please include a copy of your and/or your spouse's Medicare card, if applicable, with this form.

Member's Signature: _____ **Date:** _____

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SPOUSAL HEALTH COVERAGE INFORMATION FORM

THIS FORM MUST BE COMPLETED BY ALL ACTIVE, MARRIED OR RECENTLY DIVORCED OR WIDOWED PARTICIPANTS AND RETURNED TO THE FUND OFFICE BEFORE YOUR SPOUSE WILL BE ELIGIBLE FOR BENEFITS.

The Board of Trustees of the Teamsters Local 639—Employers Health Trust Fund has adopted a spousal surcharge requirement for the 639 Health Plan ("Plan"). This requirement is described more fully in the Summary Plan Description ("SPD") effective January 1, 2011. To satisfy this requirement, both you and your spouse must complete and sign this Form, enclose the information requested on the next few pages, and hand deliver or mail the Form and the enclosures to the Fund Office (at the address set out above).

Failure to return a completed and signed Form and supporting documentation will cause your spouse's coverage to be suspended and/or terminated.

PART 1 PARTICIPANT AND SPOUSE INFORMATION

Name of Participant:
Participant's Social Security No.:
Participant's Address:
Name of Spouse:
Spouse's Social Security No.:
Name, Address and Telephone No. of Spouse's Employer

Making a false statement on this Form is a federal crime in violation of § 1027 of the United States Criminal Code (18 U.S.C.), which is punishable by a fine of up to $10,000, five years in prison, or both, and may result in loss of coverage under the Plan.

PART 2 SPOUSAL HEALTH COVERAGE INFORMATION

YOU MUST CHECK ONE OF THE BOXES BELOW. CONTACT THE FUND OFFICE AT (202) 636-8181 IF YOU HAVE QUESTIONS.

Box 1 ☐	**I Am Not Married or Am No Longer Married:** I do not need spousal coverage from the Plan because I am not married. If I have previously reported having a spouse to the Plan, attached is a copy of my divorce decree proving I am now single.

Box 2 ☐	**My Spouse Is Not Employed:** My spouse is not employed and therefore does not have health coverage through her/his employer. As proof, **I have enclosed** our most recent and signed Form 1040 and W-2s which confirm that my spouse is not employed. If the tax form indicates employment, but your spouse is no longer employed, please provide a termination letter from your spouse's employer. Subject to the Plan's verification, I understand that the Plan will continue to provide my spouse with health coverage and **will not require us to pay the spousal surcharge**.

Box 3 ☐	**My Spouse Is Employed, But Her/His Employer Does Not Offer Health Coverage:** My spouse is employed, but my spouse's employer does not offer any health coverage or she/he is not eligible for any coverage that is offered. As proof, **I have enclosed** a letter from my spouse's employer confirming that my spouse's employer does not offer any employer sponsored health coverage. You may contact my spouse's employer to verify this information. (If your spouse is self-employed please have spouse provide a notarized statement indicating no health coverage.) Subject to the Plan's verification, I understand that the Plan will continue to provide my spouse with health coverage and **will not require us to pay the spousal surcharge**.

Box 4 ☐	**My Spouse Is Employed. My Spouse's Employer Does Offer Health Coverage, But That Coverage Is Not "Adequate," as Explained Below:** My spouse is employed and my spouse's employer does offer health coverage. However, her/his employer's plan does not meet the Plan's definition of "adequate alternate coverage" (defined in the SPD, page 13) because all of the individual coverage options would require my spouse to pay a monthly contribution of **more than $330.** As proof, **I have enclosed** either: (a) a copy of my spouse's open enrollment materials from her/his most recent open enrollment; or (b) a signed statement from my spouse's employer confirming that all individual coverage options under the employer's plan require monthly contributions of more than $330. You may contact my spouse's employer to verify this information. Subject to the Plan's verification, I understand the Plan will continue to provide my spouse with health coverage and **will not require us to pay the spousal surcharge**.

Making a false statement on this Form is a federal crime in violation of § 1027 of the United States Criminal Code (18 U.S.C.), which is punishable by a fine of up to $10,000, five years in prison, or both, and may result in loss of coverage under the Plan.

Box 5 ☐

My Spouse Is Employed. My Spouse's Employer Offers Health Coverage, But That Coverage Is Not "Adequate," as Explained Below:

My spouse is employed and my spouse's employer does offer health coverage. However, her/his employer's plan does not meet the Plan's definition of "adequate alternate coverage" (defined in the SPD, page 13) because all of the individual or family coverage options are High Deductible Health Plans (HDHPs) as defined by the IRS. The following table shows the minimum annual deductible and maximum annual deductible and other out-of-pocket expenses for HDHPs for 2018.

	Self-only coverage	Family coverage
Minimum annual deductible	$1,400	$2,800
Maximum annual deductible and other out-of-pocket expenses*	$8,550	$17,100

*The above amounts only apply to deductibles and expenses for in-network services if the plan uses a network of providers.

Self-only HDHP coverage is an HDHP covering only an eligible individual. Family HDHP coverage is an HDHP covering an eligible individual and at least one other individual (whether or not that individual is an eligible individual.

As proof, **I have enclosed** either: (a) a copy of my spouse's enrollment materials from her/his most recent open enrollment; or, (b) a signed statement from my spouse's employer confirming that all individual coverage options under the employer's plan is a high deductible health plan. You may contact my spouse's employer to verify this information.

Subject to the Plan's verification, I understand the Plan will continue to provide my spouse with health coverage and **will not require us to pay the spousal surcharge**.

Box 6 ☐

My Spouse Is Employed. My Spouse's Employer Offers "Adequate" Coverage, But My Spouse Can't Enroll in That Coverage Now:

My spouse is employed and has "adequate alternate coverage" (defined in the SPD, page 13) available through her/his employer. However, my spouse has specifically asked her/his employer when my spouse may enroll in the employer's plan and the employer has informed my spouse that she/he will not be able to enroll in that coverage until:

_____

Insert date at which spouse can first become eligible for alternate coverage through her/his employer

As proof, **I have enclosed**: (a) my spouse's open enrollment materials from her/his most recent open enrollment confirming the above open enrollment dates; or (b) a letter from my spouse's employer confirming that my spouse will not be eligible to enroll in her/his employer sponsored plan until the date specified above.Subject to the Plan's verification, I understand the Plan will continue to provide my spouse with primary coverage and **will not require us to pay the spousal surcharge** until the date set out above. **AFTER THAT DATE, I UNDERSTAND THAT MY SPOUSE WILL HAVE TO ENROLL IN HER/HIS EMPLOYER'S PLAN OR START PAYING THE SPOUSAL SURCHARGE TO THE PLAN**.

Making a false statement on this Form is a federal crime in violation of § 1027 of the United States Criminal Code (18 U.S.C.), which is punishable by a fine of up to $10,000, five years in prison, or both, and may result in loss of coverage under the Plan.

Box 7 ☐	**My Spouse Is Employed and Has Obtained "Adequate" Coverage From Her/His Employer:** My spouse is employed and is currently enrolled in coverage offered by his/her employer. Therefore, I understand that the Plan will provide my spouse with "secondary" coverage only (my spouse's employer sponsored coverage will be "primary") and **will not require us to pay the spousal surcharge**. [If you have not already done so, please complete the enclosed Coordination of Benefits form.]

Box 8 ☐	**My Spouse Is Employed and Can Obtain "Adequate" Health Coverage from Her/His Employer, But Wants to Be Covered under the Plan Instead:** My spouse is employed and has "adequate alternate coverage" (defined in the SPD, page 13) available through her/his employer, but my spouse has decided not to enroll in her/his employer's plan. My spouse wants to stay covered by the Plan and **we will pay the monthly spousal surcharge**, currently set at $388/month. My spouse and I understand that the spousal surcharge payment must be made in advance of the month for which spousal coverage is requested. **IF PAYMENT IS NOT RECEIVED ON A TIMELY BASIS, COVERAGE WILL BE TERMINATED AND MY SPOUSE WILL NOT BE PERMITTED TO RE-ENROLL IN SPOUSAL COVERAGE FROM THE PLAN FOR A PERIOD OF 12 MONTHS**.

Box 9 ☐	**My Spouse Is Employed and Can Obtain "Adequate" Health Coverage From Her/His Employer, But Will Not Obtain Coverage Either From Her/His Employer or From the Plan:** My spouse is employed and does have "adequate alternate coverage" (defined in the SPD, page 13) available through her/his employer, but my spouse has decided not to enroll in her/his employer's plan. Furthermore, we will not enroll in or pay the Plan's monthly spousal surcharge. **My spouse and I understand that she/he will not be covered by the Plan and that she/he will not be able to re-enroll in spousal coverage under the Plan for a 12-month period.**

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PART 3 PARTICIPANT AND SPOUSE CERTIFICATION

I/we certify, under penalty of perjury, that the information provided on this Form and submitted herewith is complete and accurate. I/we understand that, in addition to possible criminal penalties, the Plan may suspend my coverage and my family's coverage for a period of one year and require us to repay all benefits paid by the Plan on the spouse's behalf, if I/we make false or incorrect statements about my spouse's employment status or the health coverage that is or is not available through my spouse's employer.

Participant Signature: _____

Date: _____

Spouse Signature: _____

Date: _____

RETURN THIS FORM, COMPLETED AND SIGNED, AND WITH THE REQUIRED ACCOMPANYING MATERIALS, TO THE FUND OFFICE IN ORDER FOR YOUR SPOUSE TO BE ELIGIBLE FOR BENEFITS. THE ADDRESS OF THE FUND OFFICE IS STATED AT THE TOP OF THE FIRST PAGE OF THIS FORM.

Making a false statement on this Form is a federal crime in violation of § 1027 of the United States Criminal Code (18 U.S.C.), which is punishable by a fine of up to $10,000, five years in prison, or both, and may result in loss of coverage under the Plan.

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) TO A FAMILY MEMBER, UNION REPRESENTATIVE, OR OTHER PERSON

Explanation of this Form: The Health Insurance Portability and Accountability Act ("HIPAA") privacy regulations, which provide you with certain rights related to your protected health information ("PHI"), became effective on April 14, 2003. In general, these privacy regulations prohibit, among other things, the Teamsters Local 639 - Employers Health and Pension Funds (the "Funds") from disclosing your PHI without your permission. You may, however, authorize the Funds to disclose your PHI to a family member, union representative, or other person by completing the following Authorization. You may complete an Authorization allowing the designated individuals to have on-going access to your PHI or you may complete an Authorization each time that you want PHI disclosed to a designated individual. Please note, however, that you are not required to authorize the Funds to share your PHI with a family member, union representative, or anyone else.

1. My name is _____and my Social Security Number is _____. (If I am a dependent, the participant through whom I am covered by the Funds is _____ and his/her Social Security Number is _____). I hereby authorize my PHI to be disclosed as described in this Authorization.

2. I authorize the Funds to release PHI related to my health claims and eligibility records to the individuals identified in Section 4. This information may be given orally or in writing and may include, but is not limited to, claims detail, claims status reports, payment records, Explanation of Benefits forms, and coordination of benefits information.

3. This PHI is to be used by the individuals identified in Section 4 for the purposes of assisting me with obtaining necessary medical care, filing health care claims on my behalf, checking on the status of health care claims, and working with the Funds to resolve any other issues that may arise with respect to the health benefits that are provided to me by the Funds.

4. I authorize my above-described PHI to be disclosed only to the following identified individuals: *(There is no limit to the number of individuals you can list in this section.)*

_____	_____
Name and SSN	*Describe Relationship (i.e. spouse, parent, union representative – this is optional)*
_____	_____
Name and SSN	*Describe Relationship (i.e. spouse, parent, union representative – this is optional)*

5. I also request that the following limitations be placed on the disclosure of my PHI to the individuals identified in Number 4: *(This Section should only be filled out if you wish to limit the disclosures of your PHI to the individuals identified in Section 4.)*

_____

_____

6. I understand that the Funds may not condition my treatment, payment, enrollment, or eligibilityfor benefits on whether I agree to sign this Authorization.

7. I understand that once my PHI is disclosed pursuant to this Authorization, the federal privacy protections will no longer apply to the disclosed PHI, and thus, the individuals described in Section 4 to whom my PHI is disclosed may re-disclose that PHI.

8. I understand that I have the right to revoke this Authorization at any time by sending a letter or revocation form:

Privacy Officer
Teamsters Local 639 - Employers Health and Pension Trusts3130 Ames Place, NE
Washington, DC 20018-1593.

I understand that the revocation will take effect on the date that it is received by the Privacy Officer. However, I understand that any revocation will be effective only to the extent that the Funds has not already disclosed my PHI based on this Authorization.

9. This Authorization will expire at the end of my enrollment in the Funds or, if earlier, on the following date or event:
_____ (*e.g., One year from the date I signed the Authorization)*

_____
Printed name (of person giving authorization)

_____ _____
Signature of person giving authorization Date

_____
Name of Personal Representative (if applicable)

_____ _____
Signature of Personal Representative (if applicable Date

_____
Description of Personal Representative's authority to act for the individual (if applicable)