TILE INDUSTRY TRUST FUNDS
LOCAL # 18

VITAL INFORMATION FORM

CHECK ALL THAT APPLY: ☐ New Enrollment ☐ Adding Dependents ☐ Plan Change ☐ Beneficiary Change ☐ Address Change

EMPLOYEE'S FULL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ DATE OF BIRTH: _____

PHONE NUMBER: (_____) _____ SEX: _____Male _____ Female _____

MEDICAL PLAN (CHOOSE ONE):	**DENTAL:**
☐ **PACIFICARE HMO**	**AMERITAS GROUP**
☐ **KAISER**	**VISION:**
IF ENROLLING IN PACIFICARE OR KAISER, YOU MUST ALSO FILL OUT A PACIFICARE OR KAISER ENROLLMENT FORM (ENCLOSED).	PROVIDED BY VISION SERVICE PLAN

Medicare Claim Number including the letter(s) that follows the number
(only applies when member, spouse, or a covered dependent is age 65 or older or on Medicare disability – Please include copy of card)

Member #: _____ Spouse# _____ Dependent Name: # _____

DEPENDENTS - (Including Spouse)

(ATTACH LEGAL DOCUMENTATION THAT APPLIES: original copies of birth certificate(s), marriage certificate, adoption papers, guardianship papers)

FULL NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER

BENEFICIARY (ies): (Life Insurance)

If a minor is named as beneficiary, insurance proceeds can only be paid to a legally appointed/qualified guardian.

NAME	RELATION	BIRTHDAY	S.S. #	ADDRESS/CITY/STATE/ZIP	%
(Primary)					
(Secondary)					

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.

DATE: _____ **MEMBER SIGNATURE** _____

OTHER INSURANCE INQUIRY

Please complete and return this form, if you, your spouse, or any of your dependents have other insurance coverage, or if there has been any change in other insurance coverage.

** Please include a copy of the FRONT AND BACK of each card (Medical, Dental, Vision) *

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

General Information:

Member's Name: _____ SSN or ID#: _____

Name of Other Insured Person (Policy Holder): _____

Other Policy Holder's Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Does this plan include **Medical** coverage? YES NO If yes, is this plan an: HMO or PPO

Name of Medical Carrier: _____ Phone #: _____

Address: _____

Effective Date: _____ Termination Date (if applicable): _____ Policy/Group Number: _____

Does this plan include **Dental** coverage? YES NO If yes, is this plan an: HMO or PPO

Name of Dental Carrier: _____ Phone #: _____

Address: _____

Effective Date: _____ Termination Date (if applicable): _____ Policy/Group Number: _____

Does this plan include **Vision** coverage? YES NO If yes, is this plan an: HMO or PPO

Name of Vision Carrier: _____ Phone #: _____

Address: _____

Effective Date: _____ Termination Date (if applicable): _____ Policy/Group Number: _____

If other coverage is for a child, please circle one regarding you and the other parent:

Married Divorced Domestic Partner (boyfriend/girlfriend)

- **If divorced or separated from other parent, please include a full copy of your Dissolution of Marriage Judgment or other child custody documents.**

Coverage is (circle): Single Family

Children are covered until age: _____

List **ALL** Covered Dependents including Spouse if applicable.

1. _____ 3. _____

2. _____ 4. _____

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.

_____ _____

Member/Dependent Signature **Date**