IBEW 125 - PGE
HEALTH & WELFARE TRUST

Portland General Electric

ENROLLMENT FORM EARLY RETIREE PLAN

CHECK ALL THAT APPLY: □ **New Enrollment** □ **Adding Dependents** □ **Dropping Dependents** □ **Address Change**

EMPLOYEE'S FULL LEGAL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ DATE OF BIRTH: _____

PHONE NUMBER: (_____) _____ GENDER: (Circle One) Male Female

MARITAL STATUS: ☐Married (Date of Marriage) _____ ☐Single ☐Divorced (Date of Divorce) _____ ☐Domestic Partner

☐ Domestic Partnership Dissolution (Date of dissolution) _____

DATE OF HIRE:_____ EVENT DATE:_____ EFFECTIVE DATE:_____

MEDICAL/PRESCRIPTION:
REGENCE BLUECROSS BLUESHIELD OF OREGON (Group#71318001)

DENTAL PLAN OPTIONS
MODA (ODS) DENTAL (Group#10000153) □ Enroll in Dental coverage □ DO NOT enroll in Dental coverage

Note: IF YOU, YOUR SPOUSE, YOUR DOMESTIC PARTNER, OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE OR MEDICARE ELIGIBLE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

DEPENDENTS - (INCLUDING SPOUSE/DOMESTIC PARTNER)
(ATTACH LEGAL DOCUMENTATION THAT APPLIES FOR EACH DEPENDENT YOU ARE ENROLLING)

FULL NAME	SSN	GENDER	DATE OF BIRTH	RELATIONSHIP

I agree to notify the Trust 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 it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of defrauding obtaining plan coverage. Penalties may include imprisonment, fines, and denial of benefits.

EMPLOYEE SIGNATURE _____ **DATE** _____

-OVER-

OTHER INSURANCE INQUIRY

Please complete this page, if you, your spouse, your domestic partner, or any of your dependents have other insurance coverage, or if there has been any change in other insurance coverage.

☐ ***If you and/or your dependents DO NOT have any other insurance coverage, please check this box and sign/date at bottom of the page (under "Member Statement").***

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: _____

****** 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

Information about Other Insurance Plan or Program:

1. 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: _____

2. 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: _____

3. 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 Other (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/Domestic Partner 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 Trust 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**