IDAHO PIPE TRADES TRUST (IPTT) H&W PLAN

1220 SW MORRISON ST, STE 300, PORTLAND, OR 97205-2222

www.iptt.org 208-288-1610 or 800-808-1687 Fax 208-288-1670 iptt@aibpa.com

HEALTH & WELFARE PLAN ANNUAL ENROLLMENT EFFECTIVE JANUARY 1, 2018

ALL PARTICIPANTS MUST COMPLETE AND RETURN THIS FORM PROMPTLY TO IPTT DURING OCTOBER 23, 2017 AND NO LATER THAN NOVEMBER 23, 2017.

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Participant's Name **Social Security Number (SSN)** **Address *(notify IPTT if your address changes)*** **Phone #**

☐ **NO CHANGES** from dependents covered in 2017 to dependents covered in 2018 (refer to dependents listed on enclosed **letter)** or, if you have no dependents. **If NO CHANGES, stop here – read, sign and date back of form and send to IPTT no later than November 23, 2017.**

OR

☐ **YES, CHANGES or ADDITIONS (to dependents listed on enclosed letter):** complete form with ALL eligible dependents you want covered in 2018. Return this form and copies of marriage & birth certificates (if you haven't previously done so) to IPTT no later than November 23, 2017. Please provide marriage and/or birth certificates in order to enroll your spouse and/or dependents.

☐ Add ☐ Change ☐ Remove

Covered by any other Insurance (not IPTT)?

	First Name	Last Name	Birth Date	SSN (required)	Check all that apply: Medical/Rx	Dental	Vision	Policyholder Name & Birth date
1.								

Is the other coverage through this dependent's employer? Yes ☐ No ☐

Address (if different from yours):____ Phone Number

Individual's relationship to you: ______________________________

☐ Add ☐ Change ☐ Remove

Covered by any other Insurance (not IPTT)?

	First Name	Last Name	Birth Date	SSN (required)	Check all that apply: Medical/Rx	Dental	Vision	Policyholder Name & Birth date
2.								

Is the other coverage through this dependent's employer? Yes ☐ No ☐

Address (if different from yours):____ Phone Number

Individual's relationship to you: ______________________________

(O V E R – SIGNATURES REQUIRED ON BACK OF FORM)

☐ Add ☐ Change ☐ Remove

Covered by any other Insurance (not IPTT)?

3.

First Name	Last Name	Birth Date	SSN (required)	Medical/Rx	Dental	Vision	Policyholder Name & Birth date

(Check all that apply: Medical/Rx, Dental, Vision)

Is the other coverage through this dependent's employer? Yes ☐ No ☐

Address (if different from yours):____

Phone Number

Individual's relationship to you: ______________________________

☐ Add ☐ Change ☐ Remove

Covered by any other Insurance (not IPTT)?

4.

First Name	Last Name	Birth Date	SSN (required)	Medical/Rx	Dental	Vision	Policyholder Name & Birth date

(Check all that apply: Medical/Rx, Dental, Vision)

Is the other coverage through this dependent's employer? Yes ☐ No ☐

Address (if different from yours):____

Phone Number

Individual's relationship to you: ______________________________

☐ Add ☐ Change ☐ Remove

Covered by any other Insurance (not IPTT)?

5.

First Name	Last Name	Birth Date	SSN (required)	Medical/Rx	Dental	Vision	Policyholder Name & Birth date

(Check all that apply: Medical/Rx, Dental, Vision)

Is the other coverage through this dependent's employer? Yes ☐ No ☐

Address (if different from yours):____

Phone Number

Individual's relationship to you: ______________________________

♠ **VERY IMPORTANT – PLEASE READ:**

♠ If your Spouse works at least 20 hours per week or 80 hours per month and has group insurance coverage available through an employer but does not elect that coverage, your Spouse will not be considered an Eligible Dependent and the Plan will not cover your Spouse's claims for benefits under the Plan. This applies whether or not your Spouse must pay for the other coverage. See pages 8 & 9 of the SPD.

♠ NOTIFYING THE PLAN OF OTHER COVERAGE CHANGES : If you or your spouse or dependents become eligible for and/or enrolled in or loses other group health coverage you are required to notify IPTT in writing within 30 days by completing a Health & Welfare Plan Change Form. Failure to notify IPTT of other coverage changes and/or any false statements or misrepresentation on this form is considered fraudulent and may result in retroactively terminating plan coverage and you will be responsible for reimbursement for all amounts paid in connection with such coverage. See page 47 of the SPD.

♠ **DECLARATION:** I have provided the above information to the very best of my knowledge. I declare under penalty of perjury under the laws of the United States of America that **the foregoing is true and correct**. I understand Section 1027 of Title 18 of the United States Code makes it a crime to knowingly make a false statement in any document required to be kept by or certified to the administrator of a pension or health/welfare plan. I further understand that the punishment for violation of this law can be both a fine up to $10,000 and imprisonment for as long as five years.

♠ **ACKNOWLEDGMENT**: I understand and acknowledge that in order to process claims for benefits, physicians, hospitals or other medical providers may share information with Idaho Pipe Trades Health & Welfare Trust or their representatives regarding my or my dependents' health history, symptoms, treatment, examination results or diagnosis.

THIS FORM MUST BE RETURNED TO IPTT DURING THE MONTH OF NOVEMBER AND NO LATER THAN NOVEMBER 23, 2017.

______________________________	__________	______________________________	__________
Participant's Signature (required)	Date	Spouse's Signature (required)	Date