IDAHO PIPE TRADES TRUST (IPTT) H&W PLAN

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HEALTH & WELFARE PLAN CHANGE FORM

Use this form to:
- ☐ **change** your address or a dependent's address OR **add** a new address for a dependent.
- ☐ **add** other Insurance coverage for a dependent (list Effective Date of other Insurance coverage).
- ☐ **take away** other Insurance coverage for a dependent. **IPTT must receive a copy of the Creditable Coverage Certificate (CCC)** from the other Insurance company showing the dates the dependent was covered (start date & end date) before IPTT can provide primary coverage.

Participant's Name	Birth Date	Social Security (SSN)	NEW Address	NEW Phone Number

List dependents:
- with a **NEW** address (if different from yours) OR
- **adding** other Insurance coverage (list Effective Date of other Insurance) OR **taking away** other Insurance coverage (list End Date of other Insurance)

☐ Add ☐ Change ☐ Remove

1.

First Name	Last Name	Birth Date	SSN (required)	**Covered by any other Insurance (not IPTT)?** Check all that apply: Medical/Rx	Dental	Vision	Policyholder Name & Birth date

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

NEW Address (if different from yours): _____

Individual's relationship to you: _____ Phone Number

☐ Add ☐ Change ☐ Remove

2.

First Name	Last Name	Birth Date	SSN (required)	**Covered by any other Insurance (not IPTT)?** Check all that apply: Medical/Rx	Dental	Vision	Policyholder Name & Birth date

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

NEW Address (if different from yours): _____

Individual's relationship to you: _____ Phone Number

☐ Add ☐ Change ☐ Remove

3.

First Name	Last Name	Birth Date	SSN (required)	**Covered by any other Insurance (not IPTT)?** Check all that apply: Medical/Rx	Dental	Vision	Policyholder Name & Birth date

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

NEW Address (if different from yours): _____

Individual's relationship to you: _____ Phone Number

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

☐ Add ☐ Change ☐ Remove

Covered by any other Insurance (not IPTT)?

4.

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

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

NEW Address (if different from yours): _____

Individual's relationship to you: _____ Phone Number

☐ Add ☐ Change ☐ Remove

Covered by any other Insurance (not IPTT)?

5.

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

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

NEW Address (if different from yours): _____

Individual's relationship to you: _____ Phone Number

♠**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 9 - 11 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 60 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 46 & 47 of the SPD.

♠ If you are adding a dependent you must complete a MID YEAR STATUS CHANGE ENROLLMENT FORM located on the www.iptt.org site under Health & Welfare Forms.

♠**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.

_____ _____

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