IDAHO PIPE TRADES TRUST (IPTT) H&W PLAN

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www.iptt.org

Enrollment Form Due Within 60 DAYS of a Marriage, birth, Adoption, Divorce, or other qualified status change

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HEALTH & WELFARE PLAN ADD OR REMOVE DEPENDENT MID YEAR STATUS CHANGE ENROLLMENT FORM

Use this form to add update eligibility of dependent(s) to your Health & Welfare Plan benefits with IPTT. **YOU MUST LIST YOUR DEPENDENTS ON THE ENROLLMENT FORM AND RETURN IT WITHIN 60 DAYS OF A MARRIAGE, BIRTH OR ADOPTION, TO THE ADMINISTRATIVE OFFICE OR YOUR DEPENDENTS WILL HAVE NO COVERAGE FOR THE CALENDAR YEAR.** You must submit a copy of a marriage certificate, if adding a spouse (or divorce decree in case of divorce) and copies of certified birth certificates for children. You have 60 days after the date of the life event to submit legal documentation, which is 120 days of the life event. Claims will NOT be processed for enrolled dependents until the Administrative Office receives the required copies of marriage or birth certificates.

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

List dependents to be covered by IPTT: (**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.)

☐ 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 coverage through this dependent's employer? Yes ☐ No ☐

Address (if different from yours): _____

Phone Number

Individual's relationship to you: _____

☐ 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 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)?

	First Name	Last Name	Birth Date	SSN (required)	Check all that apply: Medical/Rx	Dental	Vision	Policyholder Name & Birth date
3.								

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
4.								

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
4.								

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 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.

♠**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