

Add Change Remove

Covered by any other Insurance (not IPTT)?

3.	First Name	Last Name	Birth Date	SSN (required)	Check all that apply:			Policyholder Name & Birth date
					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: _____

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Covered by any other Insurance (not IPTT)?

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

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

Address (if different from yours): _____ Phone Number _____

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Covered by any other Insurance (not IPTT)?

5.	First Name	Last Name	Birth Date	SSN (required)	Check all that apply:			Policyholder Name & Birth date
					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 SPD Pages 9-11.

♣ 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 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