

IDAHO PIPE TRADES TRUST (IPTT) H&W PLAN

575 N RALSTIN ST STE B, MERIDIAN ID 83642-4095
208-288-1610 or 800-808-1687 Fax 208-288-1670 www.iptt.org

**Enrollment Form Due Within
60 DAYS of a Marriage**

**Enrollment Form Due Within
60 DAYS of Birth or Adoption**

HEALTH & WELFARE PLAN ADD NEW DEPENDENT ENROLLMENT FORM

To add your Dependent to your coverage, you must provide a completed Enrollment Form and the necessary legal documentation to the Administrative Office. You must submit the **Enrollment Form within 60 DAYS of a marriage, birth or adoption (a copy of the marriage certificate or birth certificate must be submitted within 90 days of dependent's eligibility date)**. Claims will NOT be processed for enrolled dependents until the Administrative Office receives the **required legal documentation: copies of marriage or birth certificates**. If documentation is not received, dependents can not be enrolled until next annual enrollment.

Participant's Name	Birth Date	Social Security Number (SSN)	Address (<i>notify IPTT if your address changes</i>)	Phone Number
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List **new** 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 10 & 11 of the SPD.)

Covered by any other Insurance (not IPTT)?

1.	First Name	Last Name	Birth Date	SSN (required)	Check all that apply: Medical/Rx Dental Vision	Policyholder Name & Number/I.D.	Policyholder's Birth date
							Is the other coverage through this dependent's employer? Yes <input type="checkbox"/> No <input type="checkbox"/>
Address (if different from yours): _____							Phone Number
Individual's relationship to you: _____							

Covered by any other Insurance (not IPTT)?

2.	First Name	Last Name	Birth Date	SSN (required)	Check all that apply: Medical/Rx Dental Vision	Policyholder Name & Number/I.D.	Policyholder's Birth date
							Is the other coverage through this dependent's employer? Yes <input type="checkbox"/> No <input type="checkbox"/>
Address (if different from yours): _____							Phone Number
Individual's relationship to you: _____							

Covered by any other Insurance (not IPTT)?

3.	First Name	Last Name	Birth Date	SSN (required)	Check all that apply: Medical/Rx Dental Vision	Policyholder Name & Number/I.D.	Policyholder's Birth date
							Is the other coverage through this dependent's employer? Yes <input type="checkbox"/> No <input type="checkbox"/>
Address (if different from yours): _____							Phone Number
Individual's relationship to you: _____							

▲VERY IMPORTANT - PLEASE READ:

▲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
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