

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

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.
- Use this form to **add** other Insurance coverage for a dependent (list Effective Date of other Insurance coverage).
- Use this form to **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	Social Security Number (SSN)	NEW Address (complete only if NEW address)	City/State/Zip	NEW Phone Number
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- 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)

Covered by any other Insurance (not IPTT)?

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

Covered by any other Insurance (not IPTT)?

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

Covered by any other Insurance (not IPTT)?

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

▲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 _____