

ENROLLMENT FORM

ANSWER ALL QUESTIONS AND RETURN TO THE FUND'S ADMINISTRATIVE OFFICE WITH ALL REQUIRED DOCUMENTS.

Plumbers & Pipe Fitters Local 430 Health & Welfare Fund

2908 North Harvard Avenue, Tulsa, OK 74115

918-836-0430

MEMBER INFORMATION

Local Union _____

Name of Member

Social Security Number

Date of Birth

Member Address

City/State/Zip Code

Phone Number

Are you covered under any other Vision or Group Health Plan? Yes No

Medicare? Yes No

Check all that Apply: Medical Vision Dental

(If Yes, you must complete Other Insurance Information below)

SPOUSE INFORMATION (submit complete copy of marriage certificate)

Female Male

Name of Spouse

Social Security Number

Date of Birth

Spouse Address

City/State/Zip Code

Phone Number

Name of Spouse's Employer

Employer's Address

City/State/Zip

Is Spouse covered under any other Vision or Group Health Plan? Yes No

Medicare? Yes No

Check all that Apply: Medical Vision Dental

(If Yes, you must complete Other Insurance Information below)

OTHER INSURANCE INFORMATION (If more than one plan, use an additional form.)

Type of Coverage

Name of Insured

Insured's ID No.

Policy/Plan Number

Family

Individual

Name of Insurance Company

Phone Number

Insurance Company Address

City/State/Zip Code

REQUIRED DOCUMENTS: To add a spouse, a marriage license is required. To add a dependent, a Birth Certificate and Social Security Card must be provided in the first 30 days.

DEPENDENT INFORMATION (submit complete copy of Birth Certificate and Social Security Card)

Name of Dependent _____ Social Security Number _____ Date of Birth _____ Male
 Female
Dependent Address _____ City/State/Zip Code _____

Relationship to Member
 Child
 Step Child
 Age 18-26

Is Dependent covered under any other Vision or Group Health Plan? No Yes (check all that apply) Medical Vision Dental

OTHER INSURANCE INFORMATION

Type of Coverage Family Individual
Name of Insured _____ Insured's Social Security Number _____ Insured Date of Birth _____

Insured's Relationship to Dependent
 Parent Self
 Step Parent Other

Insured's Phone Number _____ Insured's ID No. _____ Policy/Plan No. _____

Name of Insurance Company _____ Insurance Company's Address _____

DEPENDENT INFORMATION (submit complete copy of Birth Certificate and Social Security Card)

Name of Dependent _____ Social Security Number _____ Date of Birth _____ Male
 Female
Dependent Address _____ City/State/Zip Code _____

Relationship to Member
 Child
 Step Child
 Age 18-26

Is Dependent covered under any other Vision or Group Health Plan? No Yes (check all that apply) Medical Vision Dental

OTHER INSURANCE INFORMATION

Type of Coverage Family Individual
Name of Insured _____ Insured's Social Security Number _____ Insured Date of Birth _____

Insured's Relationship to Dependent
 Parent Self
 Step Parent Other

Insured's Phone Number _____ Insured's ID No. _____ Policy/Plan No. _____

Name of Insurance Company _____ Insurance Company's Address _____

DEPENDENT INFORMATION (submit complete copy of Birth Certificate and Social Security Card)

Name of Dependent _____ Social Security Number _____ Date of Birth _____ Male
 Female
Dependent Address _____ City/State/Zip Code _____

Relationship to Member
 Child
 Step Child
 Age 18-26

Is Dependent covered under any other Vision or Group Health Plan? No Yes (check all that apply) Medical Vision Dental

OTHER INSURANCE INFORMATION

Type of Coverage Family Individual
Name of Insured _____ Insured's Social Security Number _____ Insured Date of Birth _____

Insured's Relationship to Dependent
 Parent Self
 Step Parent Other

Insured's Phone Number _____ Insured's ID No. _____ Policy/Plan No. _____

Name of Insurance Company _____ Insurance Company's Address _____

DEPENDENT INFORMATION (submit complete copy of Birth Certificate and Social Security Card)

Name of Dependent _____ Social Security Number _____ Date of Birth _____ Male
 Female
Dependent Address _____ City/State/Zip Code _____

Relationship to Member
 Child
 Step Child
Age 18-26

Is Dependent covered under any other Vision or Group Health Plan? No Yes (check all that apply) Medical Vision Dental

OTHER INSURANCE INFORMATION Type of Coverage Family Individual
Name of Insured _____ Insured's Social Security Number _____ Insured Date of Birth _____

Insured's Relationship to Dependent
 Parent Self
 Step Parent Other

Insured's Phone Number _____ Insured's ID No. _____ Policy/Plan No. _____

Name of Insurance Company _____ Insurance Company's Address _____

FRAUD NOTICE

I UNDERSTAND THAT THE TRUST FUND IS RELYING ON MY ANSWERS ON THIS FORM. I REPRESENT, UNDER PENALTY OF PERJURY, THAT THE ANSWERS GIVEN TO ALL QUESTIONS ON THIS FORM ARE TRUE AND ACCURATE. I UNDERSTAND THAT IF I KNOWINGLY AND WITH INTENT TO DEFRAUD THE TRUST FUND, PROVIDE MATERIALLY FALSE INFORMATION OR CONCEAL, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, I MAY BE SUBJECT TO CIVIL AND CRIMINAL PENALTIES. I UNDERSTAND THAT IT IS A FEDERAL CRIME, PUNISHABLE BY FINE OR IMPRISONMENT, ORBOTH, TO KNOWINGLY MAKE FALSE STATEMENTS ON THIS ENROLLMENT FORM.

AUTHORIZATION TO RELEASE INFORMATION & PAY BENEFITS

I HEREBY AUTHORIZE ANY PHYSICIAN OR HOSPITAL TO FURNISH AND DISCLOSE ALL KNOWN FACTS CONCERNING MY CLAIM. I WILL REIMBURSE THE FUND FOR ANY OVERPAYMENT MADE TO ME OR IN MY BEHALF DUE TO ERROR ON THIS FORM.

THIS FORM MUST BE SIGNED AND DATED BY THE EMPLOYEE

I certify that the information provided on this form and its attachments is true and correct. I hereby authorize all doctors, pharmacists, hospitals, or other institutions rendering care and treatment to furnish Plumbers & Pipe Fitters Local 430 Health & Welfare fund with full information regarding treatment rendered (including copies of their records). I also authorize any union, trust fund, employer, or insurance carrier to furnish Plumbers & Pipe Fitters Local 430 Health & Welfare Fund with information regarding benefits to which I may be entitled. A copy or photocopy of this authorization shall be considered as effective and valid as the original.

Member's Signature _____ Date Signed _____

DESIGNATION OF BENEFICIARY FOR DEATH BENEFIT

YOU MAY ELECT MORE THAN ONE PRIMARY BENEFICIARY; A SECOND BENEFICIARY WOULD ONLY APPLY IN THE EVENT THAT THE PRIMARY BENEFICIARY IS NOT LIVING. (LOCAL 430 MEMBERS ONLY).

NAME (FIRST, LAST, MI) _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____
RELATIONSHIP TO MEMBER _____ ADDRESS IF DIFFERENT THAN MEMBER _____ PRIMARY OR SECONDARY? _____

NAME (FIRST, LAST, MI) _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____
RELATIONSHIP TO MEMBER _____ ADDRESS IF DIFFERENT THAN MEMBER _____ PRIMARY OR SECONDARY? _____

I HEREBY DESIGNATE THE PERSON(S) OR ENTITY(IES) NOTED ABOVE AS MY BENEFICIARY(IES) TO RECEIVE THE DEATH BENEFIT, IF ANY, PAYABLE AT MY DEATH.

SIGNATURE OF MEMBER: _____ DATE: _____