

20 CLAIM / ENROLLMENT FORM for HEALTH & SECURITY BENEFITS

MAIL FORM TO:	ALASKA PIPE TRADES U.A. LOCAL 367 HEALTH & SECURITY TRUST FUND 610 W. 54th Avenue * Anchorage AK 99518-1137 * Phone: 907-562-2810
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This is yours & your family's Claim Form & Enrollment Form for the year. This completed form must be remitted prior to your first claim for the calendar year and another fully completed form remitted should there be any changes to the information provided on this form.

PRESCRIPTION CLAIMS: Only Enstar Active members and those who's PRIMARY insurance carrier is *other than* AK Pipe Trades, should use this form to file a claim for prescriptions, all other should use their ID card at the pharmacy or a Caremark RX Claim Form. **NO CLAIMS**, including prescriptions, **WILL BE PROCESS OR PAID UNTIL A COMPLETED FORM IS IN THE CLAIMS OR TRUST OFFICE.** Once the form is received, claims going back 1 year will be processed provided you were otherwise eligible & all other required information was provided. Incomplete forms will not be accepted. **SUBMITTING A CLAIM:** After remitting this completed form, if you have a claim to remit, just clearly print the member's name & social security number on the top of the itemized bill from the provider and remit it to the claims office, address is on your ID card. Remitting this form does not guarantee eligibility.

PLEASE PRINT CLEARLY & MAIL ORIGINAL FORM to the above address - PLEASE DO NOT FAX.

GROUP:	LU 367	LU 262	ENSTAR	SHAW	FILL IN GRAY AREAS
MEMBER'S IDENTIFICATION					SPOUSE'S IDENTIFICATION
FULL NAME (First Middle Last):					
Social Security Number:					
Date of Birth:					
Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE					
Mailing Address:					
City State Zip:					
Employed?: <input type="checkbox"/> YES <input type="checkbox"/> NO					
Other Names Known As:					
Daytime Phone Number(s):					
Hm:		Wk:		Cell:	

MARITAL STATUS (Check one & fill in the date where applicable) If you are Legally Separated your Spouse is not eligible for benefits.	
SINGLE <input type="checkbox"/>	SEPARATED <input type="checkbox"/> MARRIED, Date: _____
DIVORCED, Date: _____	
LEGALLY SEPARATED, Date: _____ OTHER, Explain: _____	

DEPENDANT CHILDREN: Please complete for each Dependent child to be covered by the Alaska Pipe Trades Health & Security Plan. Dependent Children: Must be unmarried & under age 19, or age 19 - 23 provided they are a full time student. They can be natural or adopted. Step-children or a child that resides with the member in a parent-child relationship & for which the member is legally & financially responsible for their support & maintenance may also be eligible. Listing a Dependent does not guarantee eligibility. If you need more room, please use a separate sheet of paper & be sure to include all the required information.

# 1 ~ Qualified Dependent Child	# 2 ~ Qualified Dependent Child
FULL NAME (First Middle Last):	
Date of Birth: _____ Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Date of Birth: _____ Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Check the box(s) that apply if age 19 or older and is: <input type="checkbox"/> Full Time Student <input type="checkbox"/> Disabled <input type="checkbox"/> Employed <input type="checkbox"/> Married	Check the box(s) that apply if age 19 or older and is: <input type="checkbox"/> Full Time Student <input type="checkbox"/> Disabled <input type="checkbox"/> Employed <input type="checkbox"/> Married
Name of Person with Custody:	
Dependent's Mailing Address: (If same as member, write "same")	
Relationship to Member: (Check one & indicate date where applicable.)	
Natural Child: <input type="checkbox"/>	Natural Child: <input type="checkbox"/>
Step-Child: <input type="checkbox"/> Date: _____	Step-Child: <input type="checkbox"/> Date: _____
Legally Adopted: <input type="checkbox"/> Date: _____	Legally Adopted: <input type="checkbox"/> Date: _____
Legal Guardianship: <input type="checkbox"/> Date: _____	Legal Guardianship: <input type="checkbox"/> Date: _____
Other Parent-Child Relationship: <input type="checkbox"/> Date: _____	Other Parent-Child Relationship: <input type="checkbox"/> Date: _____
Explain: _____	Explain: _____

# 3 ~ Qualified Dependent Child	# 4 ~ Qualified Dependent Child
FULL NAME (First Middle Last):	
Date of Birth: _____ Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Date of Birth: _____ Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Check the box(s) that apply if age 19 or older and is: <input type="checkbox"/> Full Time Student <input type="checkbox"/> Disabled <input type="checkbox"/> Employed <input type="checkbox"/> Married	Check the box(s) that apply if age 19 or older and is: <input type="checkbox"/> Full Time Student <input type="checkbox"/> Disabled <input type="checkbox"/> Employed <input type="checkbox"/> Married
Name of Person with Custody:	
Dependent's Mailing Address: (If same as member, write "same")	
Relationship to Member: (Check one & indicate date where applicable.)	
Natural Child: <input type="checkbox"/>	Natural Child: <input type="checkbox"/>
Step-Child: <input type="checkbox"/> Date: _____	Step-Child: <input type="checkbox"/> Date: _____
Legally Adopted: <input type="checkbox"/> Date: _____	Legally Adopted: <input type="checkbox"/> Date: _____
Legal Guardianship: <input type="checkbox"/> Date: _____	Legal Guardianship: <input type="checkbox"/> Date: _____
Other Parent-Child Relationship: <input type="checkbox"/> Date: _____	Other Parent-Child Relationship: <input type="checkbox"/> Date: _____
Explain: _____	Explain: _____

IF APPLICABLE UNDER YOUR PLAN, PLEASE BE SURE TO COMPLETE & REMIT THE SEPARATE LIFE INSURANCE BENEFICIARY FORM.

OTHER MEDICAL, DENTAL OR VISION COVERAGE:

Do you, your spouse or qualified dependents have any other

Medical, Dental or Vision coverage elsewhere, other than the Alaska Pipe Trades policy? **YES NO** If yes, it is required that you fill out the below section in full. If your other policy is primary, you must use that policy before using the Alaska Pipe Trades coverage.

Circle Type of Coverage: Employer offered coverage	Individually Purchased Policy	AK Native Benefits	VA Benefits
COBRA	Medicaid / Kids Care	Other, specify: _____ Medicare (see below)	
Circle Plan Type: ACTIVE	RETIREE	DISABILITY	Plan Effective Date: _____
Circle coverages this other Plan Includes:		MEDICAL	DENTAL VISION
Who is the PRINCIPAL Member on this Plan: _____			
Insurance Company / Plan Name: _____			
Insurance Company Address: _____			
Group # &/or Group Name: _____			
List ALL persons covered by this other coverage: _____			

Do you have another medical, dental or vision policy (other than the one listed above or the Alaska Pipe Trades Policy)? **YES NO** If yes, please provide this same information for that policy on a separate sheet of paper & attach it to this form.

MEDICARE: If you have been offered Medicare coverage, please provide the below information. If you ever declined the Medicare coverage, please write "declined" & date you declined it on the appropriate line. Your Medicare effective dates are indicated on your Medicare ID card.

	Part A (Hospital) Effective Date	Part B (Physician) Effective Date
Member's Medicare Coverage:	_____	_____
Spouse's Medicare Coverage:	_____	_____

While insured under the Alaska Pipe Trades "Retiree" plan, it is required that any covered participant sign up for Medicare A & B, when offered, regardless of age.

* I UNDERSTAND that this form must be completed & remitted before coverage can be applied. I am aware of the requirements, terms, conditions, limitations, provisions, and other information related to this plan and that the actual Policy / Plan provision & Amendments will apply when paying plan benefits and determining eligibility.*

For the purpose of verifying eligibility and processing claims on behalf of myself and enrolling family members, I AUTHORIZE the release and exchange of full information regarding school enrollment, medical history, physical or mental conditions, consultation, or treatment rendered, including copies of all records between & among all doctors, dentists, psychologists, pharmacists, hospitals or other institutions providing care, treatment, consultation, drugs or supplies, and any insurance carrier, service plan, union, trust fund, provider network, school, employer, Alaska Pipe Trades Local 367, Administration Services Inc. (ASI), Symetra Insurance Company, Medical Park Family Care & any other company providing benefits under the Alaska Pipe Trades Local 367 Health & Security Plan, to the extent permitted by law. This authorization is valid until all claims, for services rendered while covered by Alaska Pipe Trades Local 367 Health & Security Plan are finalized.

* I UNDERSTAND, in general, that I have the right to learn the nature and substance of any personal information about me or my dependents that is maintained by ASI files, upon written request. If an adverse underwriting decision is made regarding coverage for myself or my dependents, ASI will notify me of the reason(s) for the decision and the source of the information upon which the action was based. In the event that I believe that any information about me or my dependents that is contained in ASI's file is inaccurate or incomplete, I may request a correction by contacting ASI, in writing, as follows: Alaska Pipe Trades Local 367 Health & Security, c/o ASI PO Box 5434, Spokane WA 99205. All requests for corrections will be carefully considered and corrections will be made when justified.*

* I UNDERSTAND that a spouse &/or dependent children may be in-eligible for Trust-paid coverage for the following reasons: (a) the member dies; (b) the member is eligible for Medicare benefits; (c) the member & spouse are legally separated; (d) the member & spouse's are divorced or (e) child(ren) are no longer determined eligible. I understand that each participant covered by the Plan has an independent right to elect COBRA coverage if he/she loses his/her Trust-paid coverage due to any of the "qualifying events" listed above; that it is the responsibility of the person desiring COBRA coverage to notify the Health & Security Trust office within 30 days of any of the listed "qualifying events"; and that further details regarding COBRA Self-Pay coverage are provided in the Summary Plan Description (SPD). **The "qualifying events" must be reported to the Trust Office within 30 days wether purchasing COBRA or not.** Any over payment in claims will require repayment.*

* I DECLARE that the statements contained in this Claim / Enrollment Form are, to the best of my belief and knowledge, true and correct and that no material information has been withheld or omitted. **I understand if the information on this form changes, I must complete & remit a new form immediately.***

* I UNDERSTAND that it is illegal, and is a felony in some states, for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an Enrollment Form containing any false, incomplete, or misleading information. In some stated, anyone found guilty of insurance fraud is subject to fines, confinement in prison, and/or denial of insurance benefits. (Alaska Insurance Code Section 21.36.380).*

Employee Signature {Required}

Date {Required}

Spouse's Signature {Required}

Date {Required}