ENROLLMENT FORM for AKPT TRUST HEALTH & SECURITY

MAIL FORM TO:	ALASKA PIPE TRADES U.A. LOCAL 367 HEALTH & SECURITY TRUST FUND 111 W. Cataldo Avenue, Suite 220 * Spokane, WA 99201 * Phone: (855) 229-0720 or (509) 328-0300

This is your Enrollment Form (EF). This completed form must be remitted prior to your first claim and another fully completed form remitted should there be any changes, such as marriage, divorce, and newborns. **For married members, we will need a copy of the marriage license. NO CLAIMS, including prescriptions, WILL BE PROCESSED OR PAID UNTIL A COMPLETED ENROLLMENT FORM IS RECEIVED IN THE CLAIMS 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 returning this completed form, if you have a claim to remit, clearly print the member's name & social security number on the top of the itemized bill. Remit it to the claims office; the address is on your ID card. Remitting this form does not guarantee eligibility. For questions regarding eligibility or claims call the Trust office at 855-229-0720.

PLEASE PRINT CLEARLY & MAIL TO: 111 W. CATALDO AVE, STE 220 SPOAKANE WA, 99201 - OR FAX TO 509-534-5910

CIRCLE GROUP: LU 367 LU 262 MOA

	MEMBER'S IDENTIFICATION				**SPOUSE'S IDENTIFICATION**			
FULL NAME (First Middle Last):								
Social Security Number:								
Date of Birth:								
Gender:		MALE		FEMALE		MALE		FEMALE
Mailing Address:								
City State Zip:								
Employed?:		YES		NO		YES		NO
Other Names Known As:								
Email Address								
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_______ SEPARATED_______ MARRIED, Date:_________________ DIVORCED, Date: _________________
LEGALLY SEPARATED, Date:___________________ OTHER, Explain: ____

DEPENDENT CHILDREN: Please complete for each dependent child to be covered by the Alaska Pipe Trades Health & Security Plan. Dependent Children: Must be under the age of 26. They can be natural, adopted or Step-children that reside with the member in a parent-child relationship. 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. **CHILDREN/DEPENDENTS WILL NOT BE ELIGIBLE WITHOUT THEIR SOCIAL SECURITY NUMBER AND A COPY OF THEIR BIRTH CERTIFICATE.**

	# 1 ~ Qualified Dependent Child	***# 2 ~ Qualified Dependent Child***
FULL NAME (First Middle Last):		
Date of Birth:	Gender: [ ] MALE [ ] FEMALE	Gender: [ ] MALE [ ] FEMALE
Check the box if age 26 or older and disabled:	[ ] Disabled	[ ] Disabled
Social Security Number:		
Name of Person with Custody:		
Dependent's Mailing Address:		
Relationship to Member:	(Check one & indicate date where applicable.)	(Check one & indicate date where applicable.)
Natural Child:	[ ]	[ ]
Step-Child:	[ ] Date:	[ ] Date:
Legally Adopted:	[ ] Date:	[ ] Date:
Legal Guardianship:	[ ] Date:	[ ] Date:
	Explain:	Explain:

	# 3 ~ Qualified Dependent Child	***# 4 ~ Qualified Dependent Child***
FULL NAME (First Middle Last):		
Date of Birth:	Gender: [ ] MALE [ ] FEMALE	Gender: [ ] MALE [ ] FEMALE
Check the box if age 26 or older and is disabled:	[ ] Disabled	[ ] Disabled
Social Security Number:		
Name of Person with Custody:		
Dependent's Mailing Address:		
Relationship to Member:	(Check one & indicate date where applicable.)	(Check one & indicate date where applicable.)
Natural Child:	[ ]	[ ]
Step-Child:	[ ] Date:	[ ] Date:
Legally Adopted:	[ ] Date:	[ ] Date:
Legal Guardianship:	[ ] Date:	[ ] Date:
	Explain:	Explain:

Edition 5/1/2016

ENROLLMENT FORM (cont. . . .)

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 o

	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, Zenith American Solutions, 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 Zenith American Solutions, upon written request. If an adverse underwriting decision is made regarding coverage for myself or my dependents, Zenith American Solutions 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 Zenith American Solutions file is inaccurate or incomplete, I may request a correction by contacting Zenith American Solutions in writing, as follows: Alaska Pipe Trades Local 367 Health & Security, c/o Zenith American Solutions, 111 W Cataldo, Ste 220, Spokane WA 99201. All requests for corrections will be carefully considered and corrections will be made when justified.*

* I UNDERSTAND that a spouse and/or dependent children may be ineligible 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 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 whether purchasing COBRA or not.** Any over payment in claims will require repayment.*

* I DECLARE that the statements contained in this 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}