Pipe Fitters Local No. 533 Health and Welfare Plan

8600 Hillcrest Road, Suite A / Kansas City, MO 64138 (ph.) 816-361-0206

2022 Active Open Enrollment

Please complete the enclosed 2022 Enrollment Forms and return to the Fund Office to ensure your Pipe Fitters Local 533 Health and Welfare account has the most current information.

- ✓ Enrollment Form
- ✓ Coordination of Benefit
- ✓ Employed Spouse Coverage Affidavit

Please submit this information no later than March 31, 2022. Your lack of response will impact claims.

If you have any questions, please contact the Benefit Office at the number listed above.

The Benefit Office

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Participant Enrollment Form

You must submit this Enrollment Form to the Fund Office by March 31, 2022

- If you are married and your spouse will be employed on January 1, 2022, you must include the Employed Spouse Coverage Affidavit if your spouse is not already enrolled in Qualifying Health Coverage through his or her employer.
- If you are married, you must include a copy of your Marriage Certificate.
- If you are enrolling a Dependent child(ren), you must include a copy of the child's birth certificate, adoption papers, or court order for custody and support or maintenance (as applicable).

Participant

Name _____
Last First Middle

Address _____
Street City State Zip

Phone _____ Date of Birth _____ Social Security Number _____

Gender M or F Email Address _____

Marital Status Single Married Divorced Widowed

Medicare Number _____ Part A _____ Part B_____

Spouse Medicare Number _____ Part A _____ Part B _____

Spouse Information

_____ _____ _____ _____
Name Date of Birth Gender SSN

Will your spouse be employed on January 1, 2022? Yes☐ No ☐
Self Employed on January 1, 2022? Yes ☐ No ☐
☐If the answer is Yes and your spouse is already enrolled in Qualifying Health Coverage through their employer, skip the next section and proceed to the Dependent Child Information section
☐If the answer is Yes and your spouse is NOT enrolled in Qualifying Health Coverage through their employer, you *must* complete the Employed Spouse Coverage Affidavit and the section below.
If the answer is No, or (s)he was self-employed, skip the next section and proceed to the Dependent Child Information section

Does your Employed Spouse Coverage Affidavit reflect your spouse is eligible for Qualifying Health Coverage as of March 31, 2022? (If this question is not applicable, proceed to the Dependent Child Information section)

☐ **Yes**, my spouse has Qualifying Health Coverage available from his/her employer as of March 31, 2022, and my spouse will enroll in such coverage by April 1, 2022**. *Please submit proof of enrollment, i.e.: copy of ID Card, completed enrollment form or letter from employer.***

(YOU MUST COMPLETE THE BACKSIDE OF THIS FORM)

☐ **Yes**, my spouse has Qualifying Health Coverage available from his/her employer as of March 31, 2022, but my spouse will not enroll in such coverage by April 1, 2022. I understand that at 11:59 p.m. on March 31, 2022, my spouse will no longer have coverage from the Pipe Fitters Local No. 533 Health and Welfare Fund

☐ **No**, my employed spouse does not have Qualifying Health Coverage available from his/her employer as of March 31, 2022.

Dependents ***(Dependent(s) must be listed to be on the policy.)*** ***If you have more than 4 eligible Dependents, attach a separate sheet of paper with those additional Dependents.***

Name	Date of Birth	Relationship	Social Security	Do they have other coverage?
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No
_____	_____	_____	_____	Yes No

***If your Spouse or your Dependent(s) have other group medical coverage, you must include a photocopy of the front and back of the I.D. card for the other coverage. If your other coverage is Medicare, please add it to the top portion of this form.**

The following is extremely important information. Please read this language carefully and then sign and date this Enrollment Form and return it to the Fund Office. If you are married, both you and your spouse must sign and date this Enrollment Form.

I hereby certify that all information on provided on this Enrollment Form is correct to the best of my knowledge. I understand that if this information changes, it is my responsibility to notify the Fund Office immediately. I also understand that I will be required to reimburse the Plan for any payments made as a result of my failure to notify the Fund Office of a change in the information provided on this Enrollment Form.

_____

Participant Signature ***Date of Signature***

_____

Spouse's Signature ***Date of Signature***

Life-Changing Events

When you get married, provide the Fund Office with:
- A copy of your marriage certificate
- Your spouse's date of birth
- A copy of your spouse's medical insurance information, if he or she is covered under another plan

If you add a child, provide the Fund Office with:
- A copy of the child's birth certificate, adoption papers, or court order for custody and support or maintenance (as applicable)
- A copy of your child's other medical insurance information, if he or she is covered under another plan

If you get legally separated or divorced, provide the Fund Office with:
- A copy of your separation or divorce decree
- A copy of any QDRO
- If you have children for whom you do not have custody, a copy of any QMCSO

Life changing events are all subject to the terms of the Pipe Fitters Local No. 533 Health and Welfare Plan Document. If you have any questions regarding enrollment, please see your Summary Plan Description or contact the Fund Office.

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Coordination of Benefits

SECTION 1

Participant Name: _____Participant ID_____

Are you, your spouse or any of your dependents covered by another health plan other than Medicare?

☐-NO – Please skip the rest of the questions Sign the bottom of this form and return.	☐- YES – Please complete the entire form, Sign the bottom of the form and return.

SECTION 2 **OTHER HEALTH COVERAGE INFORMATION**

Please provide the following information about the policyholder of the other health coverage.

Name of policyholder		Relationship to you	Birth Date
Insurance company name	Insurance company city	State	Phone number
Enrollee ID/policy number	Group number	Effective date	Cancellation date (if applicable)
Type of coverage ☐ Single ☐ Family	Type of Plan (Check all that apply) ☐ Medical ☐ Prescription drug ☐ Dental ☐ Medicare Advantage		

Who is covered by this other plan? Include yourself if applicable.

Name (first and last)	Relationship to you
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Participant signature: _____ **Date:** _____

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Employed Spouse Coverage Affidavit

Important: please ensure this form is fully completed.
Your response, or lack of response, will impact your spouse's health care coverage.

SECTION 1: **Pipefitters and Spouse Information**

Pipe Fitter Name:	Full Name of Spouse:
Pipe Fitter Date of Birth:	Phone Number:
Address:	

SECTION II: Employer Certification of Spouse's Health Insurance Coverage

Note: this section must be completed in full by your Spouse's employer

1. Does your company/organization offer health insurance to your employees that is designed to satisfy minimum essential health coverage requirements under the Affordable Care Act?
   ☐ Yes ☐No ***If the answer to #1 is yes, please proceed to #2. If no, please go to #5.***

2. As of **March 31**, of this year, is the Spouse named above eligible for your company/organization's health insurance coverage?
   ☐Yes ☐No ***If the answer to #2 is yes, please proceed to #4. If no, please go to #3.***

3. Why is the Spouse named above not eligible for your company/organization's health insurance coverage as of March 31, of this year?

☐ The Spouse is not a full-time employee and company health insurance coverage is not offered to part-time employees. **(if checked, proceed to #5)**	☐ The Spouse is in a waiting period until (date): _____ **(if checked, proceed to #5)**
☐ The Spouse did not enroll during the Open Enrollment Period. **(if checked, proceed to #4**)	☐ Other: _____ **(if checked, proceed to #4)**

4. What is the employee's cost for the least expensive employee-only coverage option available (excluding any voluntary coverage buy ups, e.g., vision, dental, etc.)? $_____per_____. **Please complete #5.**

5. Employer Information:

   Name of employer: _____ Phone: _____

   Address of employer: _____

   Name of Representative (printed) _____Title:_____

   Signature of Representative: _____ Date:_____