Pipe Fitters Local No. 533 Health and Welfare Plan
8600 Hillcrest Road, Suite A / Kansas City, MO 64138 (ph.) 816-361-0206

2022 Retiree 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

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

Pipe Fitters Local No. 533 Health and Welfare Plan

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

2022 Retiree Open Enrollment Form

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

Participant

Name _____
Last First Middle

Address _____
Street City State, Zip

Phone _____ Date of Birth _____ Social Security Number _____

Gender M or F Martial Status _____ Email Address _____

Do you have Medicare: Yes ☐ No ☐

Medicare Number _____ Part A _____ Part B_____

Do you have Medicare due to End-stage renal disease: Yes ☐ No ☐

If Yes, Effective Date: _____/_____/_____

Does your Spouse have Medicare: Yes ☐ No ☐

Spouse Medicare Number _____ Part A _____ Part B _____

Do you have Medicare due to End-stage renal disease: Yes ☐ No ☐

If Yes, Effective Date: _____/_____/_____

Dependents

Name	Date of Birth	Relationship	SSN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(OVER)

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.

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:** _____