

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

Participant Enrollment Form

Complete this Enrollment Form and return it to the Fund Office. You must submit the following items to the Fund Office with this Enrollment Form, if you have not previously provided them to the Fund Office (as applicable):

- If you are married and your spouse was employed on January 1, of this year, 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

Was your spouse employed on January 1 of this year? Yes No

Self Employed on January 1, of this year? 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, of this year? (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, of this year, and my spouse will enroll in such coverage by April 1, of this year. Please submit proof of enrollment, i.e.: copy of ID Card, completed enrollment form or letter from employer. **(OVER)**

Yes, my spouse has Qualifying Health Coverage available from his/her employer as of March 31, of this year, but my spouse will not enroll in such coverage by April 1, of this year. I understand that at 11:59 p.m. on March 31, of this year 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, of this year.

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	SSN
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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.