

# Pipe Fitters Local No. 533 Health and Welfare Plan

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

## Retiree Enrollment Form

### Participant

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State, Zip

Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Gender M or F **Marital 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Spouse/Dependents

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

**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