Teamsters Western Region & Local 177 Health Care Plan

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Phoenix, AZ 85021
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WWW.WR177HEALTHCARE.COM

ENROLLMENT FORM

IMPORTANT - DO NOT DELAY. Before benefits for you and your family can be paid this form must be sent to the Fund Office – **FULLY COMPLETED, SIGNED AND DATED BY YOU.** Without this information, the Fund Office **CANNOT CERTIFY BENEFITS** to doctors, hospitals, labs, pharmacies or any other health care provider. Do not wait until a family member needs health care. Send your completed form and required attachments to the Fund Office now.

✓ **CHECK ONE:** ☐ NEW EMPLOYEE ☐ ADD SPOUSE ☐ ADD CHILD ☐ CHANGE PERSONAL DATA

EMPLOYEE INFORMATION

LAST NAME:	FIRST NAME:	MI:	☐ M ☐ F	BIRTH DATE / /
ADDRESS	CITY	STATE ZIP		PHONE NO. ( ) -
SOCIAL SECURITY NUMBER	MARITAL STATUS ☐ Married ☐ Divorced ☐ Single ☐ Widowed			LOCAL UNION NO.

SPOUSE INFORMATION – *YOU MUST ATTACH A COPY OF YOUR MARRIAGE CERTIFICATE / DIVORCE DECREE IF APPLICABLE*

LAST NAME:	FIRST NAME:	MI:	BIRTH DATE: / /	☐ M ☐ F	SOCIAL SECURITY NO.
IS YOUR SPOUSE EMPLOYED? ☐ NO ☐ YES	IF YES – EMPLOYER:	ADDRESS:			TELEPHONE NO.

Eligibility for all persons listed shall be subject to all provisions and limitations of the Trust Agreement and Plan Document as well as to any rules or regulations adopted by the Board of Trustees. Please see your Summary Plan Description for a full explanation.

(Continued on Reverse Side)

✓ ***YOU MUST ATTACH A COPY OF THE CERTIFIED BIRTH CERTIFICATE (IF NOT PREVIOUSLY SUBMITTED)***

✓ ***SOCIAL SECURITY NUMBERS ARE REQUIRED FOR ALL DEPENDENTS.***

CHILDREN - IF ADDITIONAL SPACE NEEDED ATTACH A SEPARATE SHEET

FULL NAME (LAST,FIRST, MI)	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP TO EMPLOYEE
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)

FRAUD NOTICE

I UNDERSTAND THAT THE TRUST FUND IS RELYING ON MY ANSWERS ON THIS FORM. I REPRESENT, UNDER PENALTY OF PERJURY, THAT THE ANSWERS GIVEN TO ALL QUESTIONS ON THIS FORM ARE TRUE AND ACCURATE. I UNDERSTAND THAT IF I KNOWINGLY AND WITH INTENT TO DEFRAUD THE TRUST FUND, PROVIDE FALSE INFORMATION OR CONCEAL, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, I MAY BE SUBJECT TO CIVIL AND CRIMINAL PENALTIES. I UNDERSTAND THAT IT IS A FEDERAL CRIME, PUNISHABLE BY FINE OR IMPRISONMENT, OR BOTH, TO KNOWINGLY MAKE FALSE STATEMENTS ON THIS VERIFICATION FORM.

AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I HEREBY AUTHORIZE ANY PHYSICIAN OR HOSPITAL TO FURNISH AND DISCLOSE ALL KNOWN FACTS CONCERNING MY CLAIM. I WILL REIMBURSE THE FUND FOR ANY OVERPAYMENT MADE TO ME OR IN MY BEHALF DUE TO ERROR ON THIS FORM. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER FOR HIS SERVICES AS DESCRIBED HEREON OR IN SUPPLEMENTAL STATEMENTS, NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGES FOR THOSE SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN FORCE UNTIL CANCELLED IN WRITING BY ME.

BENEFICIARY INFORMATION PLEASE UPDATE YOUR BENEFICIARY INFORMATION. IF ADDITIONAL SPACE NEEDED ATTACH A SEPARATE SHEET

FULL NAME AND ADDRESS (PLEASE PRINT)	RELATIONSHIP
NAME: ADDRESS:	

✓ ______________________ EMPLOYEE SIGNATURE

______________________ SOCIAL SECURITY NUMBER

__________ DATE