Southwest Service Administrators, Inc.
Phoenix, AZ Service Center
P.O. Box 43110
Phoenix, AZ 85080-3110

Enrollment Form

This form must be completed fully upon **entry** into the plan **and** it may also be used to submit any updated information throughout the year. Do not wait until a family member needs health care! Send your completed form to the Fund Office NOW. You only have 60 days to enroll from your date of eligibility or 60 days from a Life Changing Event to make a change.

Entry Verifications: **IMPORTANT! Do Not Delay!** Benefits will not be paid for services received until the Fund Office receives your form—**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.

To Update Information: Complete the Employee Information section and any sections that show the change you are reporting, then send to the Fund Office.

CHECK ONE ☐ New Employee ☐ Add Spouse ☐ Add Child ☐ Change Personal Data

EMPLOYEE INFORMATION

Last Name	**First Name**	**MI**	
Date of Birth	**Social Security #***	☐ Male ☐ Female	
Home Phone	**Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed	**Local Union #**	
Mailing Address	**City**	**State**	**Zip**

DEPENDENT INFORMATION Provide the following information for each dependent you enroll.

If you are currently married and listing a spouse, attach a copy of your certified marriage certificate. For newly eligible dependent children, attach a copy of the certified birth certificate. For Medicare-eligible dependents, attach a copy of the Medicare card. Eligibility for all persons listed will be subject to all provisions and limitations of the trust agreement and plan document as well as to any rules or regulation adopted by the Board of Trustees. Please see your Summary Plan Description for a full explanation.

Relationship Codes: **SP** - Spouse **CH** - Child **SC** - Step-Child **O** - Other (Specify on an additional page)

Code	Last Name	First Name	MI	Date of Birth	Social Security # or TIN*	Gender M	Gender F

*Federal regulations require health plans to report the names and Social Security numbers of every covered individual to the IRS. Coverage will not begin until Social Security numbers have been provided.

For each dependent covered under any other insurance, complete the following information.

Dependent's Name (First, Last)	Medicare Eligible?	Other Insurance Coverage?	Employer name, if employed?
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	

If you or any of your dependents are covered by another group health plan, provide the following information and attach a copy of the plan identification card. If you need to list multiple individuals, please attach an additional page.

Covered Person's Name	**Insurance Company or Plan Name**	
Type of Coverage ☐ Medical ☐ Dental ☐ Vision	**Group I.D. or HICN #**	**Effective Date of Coverage**

LIFE AND/OR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE INFORMATION

If additional space is needed attach a separate sheet.

Last Name	**First Name**	**MI**
Relationship	**Home Phone**	**Social Security #***
Date of Birth	**Percent of Benefit**	

*Federal regulations require health plans to report the names and Social Security numbers of every covered individual to the IRS. Coverage will not begin until Social Security numbers have been provided.

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 on my behalf due to errors on this form. I hereby authorize payment directly to the provider for services as described herein 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.

Employee Signature _____ **Date** _____

Southwest Service Administrators, Inc.
Phone: (855) 292-7954
Fax: (480) 302-2237
www.SSATPA.com