

Teamsters Western Region & Local 177 Health Care Plan

P.O. Box 43110, Phoenix, AZ 85080-3110

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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.

NROLLMENT, CH	IANGE OR LIFE	E EVENT NOTICES								
ATA. IF YOU DO NOT FIL	L OUT THIS FORM CO	HECK ALL BOXES THAT APPLY. PR DMPLETELY AND ATTACH DOCUN ITTED AND THE FORM IS SIGNED	MENTATION, IT WILL B							
CHECK ALL THAT	APPLY: NEW	ENROLLMENT CHANGE	PERSONAL DATA							
REMOVE SPOUSE										
ADD SPOUSE	☐ ADD CHILD	☐ ADD FAMILY VISION	I □ ADD FAMIL	ADD FAMILY DENTAL						
) EMPLOYEE INF	ORMATION									
T NAME:		FIRST NAME:				N	II: GENDER:			
							□ M			
TH DATE:	S	SOCIAL SECURITY NO. *	AL SECURITY NO. * PHONE NO.							
/ /		/ /			()	-				
DRESS		CITY STA	TE ZIP		,					
ARITAL STATUS: LOCAL UNION NO.										
Married □ Div	orced Singl	le 🗆 Widowed								
SPOUSE INFORM	MATION - DO NOT	COMPLETE IF YOU ARE NOT O	CURRENTI Y MARRIFI	D.						
) SPOUSE INFORMATION – DO NOT COMPLETE IF YOU ARE NOT CURRENTLY MARRIED. IF MARRIED AND LISTING A SPOUSE, YOU MUST ATTACH A COPY OF YOUR MARRIAGE CERTIFICATE.										
T NAME:		FIRST NAME:		MI:	GENDER:	SOCIAL SECURI	TY NO. *			
					□ M □ F	/	/			
DRESS (IF DIFFERENT FROM	I EMPLOYEE):					BIRTH DATE:				
						1	1			
ONE NO.		IS YOUR SPOUSE EMPLOYED?	IF VFS —	EMPLOY	/FR·	,				
\										
	CARE ELIGIBLE ATTACH A	COPY OF YOUR MEDICARE CARD)								
DICARE ELIGIBLE? (IF MEDIC										
DICARE ELIGIBLE? (IF MEDIC										

- ALL CHANGES MADE DUE TO QUALIFYING LIFE EVENTS MUST BE SUBMITTED WITHIN NINETY (90) DAYS OF THE QUALIFYING LIFE EVENT IN ORDER TO BE EFFECTIVE AS OF THE EVENT DATE. OTHERWISE THE EFFECTIVE DATE WILL BE PROSPECTIVE FOR THE SUBMITTED CHANGE TO BE EFFECTIVE THE SUNDAY FOLLOWING DATE OF RECEIPT. (SOME EXAMPLES OF LIFE EVENTS INCLUDE- MARRIAGE, BIRTH, ADOPTION OR LOSS OF HEALTH COVERAGE).
- 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.
 - FOR A <u>NEWBORN</u> TO BE ENROLLED, A HOSPITAL PROOF OF LIFE DOCUMENT MAY BE ACCEPTED WITH THIS ENROLLMENT FORM FOR TEMPORARY INITIAL COVERAGE. HOWEVER, A COPY OF THE CERTIFIED BIRTH CERTIFICATE IS STILL REQUIRED WITHIN 90 DAYS OF THE CHILD'S BIRTH IN ORDER TO BE PROPERLY ENROLLED AND TO AVOID ANY TERMINATION OF COVERAGE.
 - * COVERAGE WILL NOT BEGIN UNTIL SOCIAL SECURITY NUMBERS HAVE BEEN PROVIDED
- → IF YOUR DEPENDENT(S) ARE NOT PROPERLY ENROLLED WITHIN 90 DAYS, YOUR DEPENDENT(S) MAY ONLY BE ADDED PROSPECTIVELY.
- 3) DEPENDENT(S) YOU MUST ATTACH A COPY OF THE CERTIFIED BIRTH CERTIFICATE FOR NEWLY ADDED DEPENDENTS
 IF ADDITIONAL SPACE NEEDED ATTACH A SEPARATE SHEET

FULL NAME (LAST,FIRST, MI)	SEX	DATE OF BIRTH	Social Security No. *	RELATIONSHIP TO EMPLOYEE	
	□ M	1 1	1 1	□ NATURAL/ADOPTED CHILD □ STEP CHILD □ OTHER (SPECIFY)	
	- M	1 1	/ /	□ NATURAL/ADOPTED CHILD □ STEP CHILD □ OTHER (SPECIFY)	
	М Б	1 1	1 1	□ NATURAL/ADOPTED CHILD □ STEP CHILD □ OTHER (SPECIFY)	
	М Б	1 1	1 1	□ NATURAL/ADOPTED CHILD □ STEP CHILD □ OTHER (SPECIFY)	
	- M	1 1	1 1	□ 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.

4) BENEFICIARY INFORMATION - PLEASE UPDATE YOUR BENEFICIARY INFORMATION.