

SMWIA LOCAL 49 FAMILY HEALTH PLAN

4775 Indian School Road, N.E., Suite 105

Albuquerque, New Mexico 87110

Phone (505) 265-8422 Toll Free (800) 432-6636 Fax (505) 266-9358

EMPLOYEE & DEPENDENT ELIGIBILITY INFORMATION VERIFICATION FORM

This form must be completed fully upon ENTRY into the plan, AND at the beginning of each year. It may also be used to submit any updated information throughout the year.

✓ *Entry or yearly verifications - IMPORTANT - DO NOT DELAY.* Before benefits for you and your family can be paid, your form must be sent to the fund office - **fully completed**. 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 TO THE FUND OFFICE NOW.**

✓ *To update information* - Complete the Employee Information section and sections that show the change you are reporting, and send to the Fund office.

CHECK ONE: NEW EMPLOYEE YEARLY UPDATE CHANGE OF STATUS VERIFICATION

EMPLOYEE INFORMATION					
1. LAST NAME:	FIRST NAME:	MI:	<input type="checkbox"/> M <input type="checkbox"/> F	2. BIRTH DATE / /	3. SOCIAL SECURITY NO. - -
4. ADDRESS <input type="checkbox"/> CHECK HERE IF NEW ADDRESS			CITY	STATE	ZIP
6. EMPLOYER			7. ADDRESS	CITY	STATE
				STATE	ZIP
			8. PHONE NUMBER () -		

SPOUSE INFORMATION					
9. LAST NAME:	FIRST NAME:	MI:		10. BIRTH DATE / /	11. SOCIAL SECURITY NO. - -
12. IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> NO <input type="checkbox"/> YES		IF YES - EMPLOYER:		13. ADDRESS	CITY
					STATE
					ZIP
				14. PHONE NUMBER () -	

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.

SPOUSE COORDINATION OF BENEFITS INFORMATION		
15. DOES YOUR SPOUSE'S EMPLOYER OFFER A GROUP MEDICAL PLAN INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
16. IS YOUR SPOUSE ENROLLED IN HIS/HER EMPLOYER PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES - PROVIDE NAME OF OTHER PLAN	ADDRESS	GROUP OR I.D. NO.
PLEASE INDICATE TYPE OF COVERAGE: <input type="checkbox"/> MEDICAL, <input type="checkbox"/> DENTAL, <input type="checkbox"/> VISION, <input type="checkbox"/> PRESCRIPTION DRUGS		
17. MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF MEDICARE ELIGIBLE ATTACH A COPY OF THE MEDICARE CARD)		HICN NUMBER _____

18. 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 MATERIALLY 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.

19. 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.

EMPLOYEE'S SIGNATURE _____ SOCIAL SECURITY NUMBER _____ DATE _____

20. DEPENDENT CHILDREN INFORMATION

NOTE: YOU MUST ATTACH A BIRTH CERTIFICATE FOR NEWLY ADDED DEPENDENTS. YOU MUST ATTACH A COPY OF A SCHOOL CERTIFICATE OF ENROLLMENT FORM FOR ANY DEPENDENT CHILD STUDENT AGE 19 TO 23.

FULL NAME (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY #	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
ADDRESS: <input type="checkbox"/> SAME OR:	/ /	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
ADDRESS: <input type="checkbox"/> SAME OR:	/ /	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
ADDRESS: <input type="checkbox"/> SAME OR:	/ /	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
ADDRESS: <input type="checkbox"/> SAME OR:	/ /	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:
ADDRESS: <input type="checkbox"/> SAME OR:	/ /	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER, SPECIFY:

21. DEPENDENT COORDINATION OF BENEFITS INFORMATION

IS DEPENDENT COVERED BY ANOTHER PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF MEDICARE ELIGIBLE ATTACH A COPY OF MEDICARE CARD	IF YES - SHOW NAME OF COVERED EMPLOYEE:	SOCIAL SECURITY NUMBER / /
IF YES, PLEASE INDICATE TYPE OF COVERAGE: <input type="checkbox"/> MEDICAL <input type="checkbox"/> VISION <input type="checkbox"/> RX	EFFECTIVE DATE OF COVERAGE:	GROUP OR I.D NUMBER:
NAME OF OTHER PLAN:	ADDRESS:	

22. NOTICE OF CHANGE: ADD DEPENDENT(S) DELETE DEPENDENT(S)
IF ADDING OR DELETING A DEPENDENT SPOUSE - MARRIAGE CERTIFICATE OR DIVORCE DECREE MUST BE ATTACHED

MARRIAGE <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER <input type="checkbox"/>	LAST NAME:	FIRST NAME:	SOCIAL SECURITY # / /	DOB / /
IF OTHER - PLEASE EXPLAIN:				
MARRIAGE <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER <input type="checkbox"/>	LAST NAME:	FIRST NAME:	SOCIAL SECURITY # / /	DOB / /
IF OTHER - PLEASE EXPLAIN:				

23. BENEFICIARY DESIGNATIONS **FAMILY HEALTH PLAN ONLY**** BENEFICIARY DESIGNATIONS**

LIFE INSURANCE (LOCAL 49 MEMBERS ONLY)			VACATION BENEFITS (LOCAL 49 MEMBERS ONLY)		
<input type="checkbox"/> CHECK HERE IF YOUR SPOUSE IS YOUR BENEFICIARY DO NOT COMPLETE INFORMATION BELOW			<input type="checkbox"/> CHECK HERE IF YOUR SPOUSE IS YOUR BENEFICIARY DO NOT COMPLETE INFORMATION BELOW		
NAME	DATE OF BIRTH		NAME	DATE OF BIRTH	
RELATIONSHIP	SS#		RELATIONSHIP	SS#	
ADDRESS			ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
NAT'L PENSION FUND (LOCAL 49 MEMBERS ONLY)			SASMI BENEFITS (LOCAL 49 MEMBERS ONLY)		
<input type="checkbox"/> CHECK HERE IF YOUR SPOUSE IS YOUR BENEFICIARY DO NOT COMPLETE INFORMATION BELOW			<input type="checkbox"/> CHECK HERE IF YOUR SPOUSE IS YOUR BENEFICIARY DO NOT COMPLETE INFORMATION BELOW		
NAME	DATE OF BIRTH		NAME	DATE OF BIRTH	
RELATIONSHIP	SS#		RELATIONSHIP	SS#	
ADDRESS			ADDRESS		
CITY	STATE	ZIP	CITY	STATE	ZIP
<input type="checkbox"/> PLEASE CHECK HERE IF YOU WOULD LIKE TO RECEIVE NEW MEDICAL ID CARDS					