**SHEET METAL WORKERS LOCAL 49**
**FAMILY HEALTH PLAN**
**2300 BUENA VISTA SE, STE. 127, ALBUQUERQUE, NM 87106**
**PHONE: 505-265-8422 • TOLL FREE: 800-432-6636 • FAX: 505-266-9358**
www.ssatpa.com

# EMPLOYEE & DEPENDENT ENROLLMENT FORM

**IMPORTANT - DO NOT DELAY**
IF YOU DO NOT SUBMIT THE ENROLLMENT FORM ALONG WITH REQUIRED DOCUMENTATION, BENEFITS FOR YOU AND YOUR FAMILY CANNOT BE CERTIFIED OR PAID. DO NOT WAIT UNTIL A FAMILY MEMBER NEEDS HEALTH CARE, SEND YOUR COMPLETED FORM TO THE FUND OFFICE TODAY.

**CHECK ALL THAT APPLY:** **NEW EMPLOYEE_____** **ADD SPOUSE, NEWBORN/CHILD_____** **CHANGE PERSONAL DATA_____**

## EMPLOYEE INFORMATION

| LAST NAME | FIRST NAME | MI | GENDER | BIRTH DATE | SOCIAL SECURITY NO. |
|---|---|---|---|---|---|
| | | | | | |

ADDRESS CITY STATE ZIP

| HOME PHONE | CELL PHONE | EMAIL ADDRESS |
|---|---|---|
| | | |

| EMPLOYER NAME | EMPLOYER ADDRESS | EMPLOYER PHONE NO. |
|---|---|---|
| | | |

ARE YOU COVERED BY ANOTHER INSURANCE PLAN? YES___ NO___ IF YES, PROVIDE NAME OF INSURANCE PLAN: ________________________________
MEDICAL___ DENTAL ___ EFFECTIVE DATE OF INSURANCE POLICY:__________________ POLICY # ________________ GROUP OR ID#:_______________

**(ATTACH COPY OF INSURANCE CARD)**

IF YOU ARE ADDING A SPOUSE AND/OR DEPENDENT, YOU MUST SUBMIT AN ORIGINAL MARRIAGE CERTIFICATE AND AN ORIGINAL BIRTH CERTIFICATE FOR DEPENDENTS WITH THE ENROLLMENT FORM. THE FUND OFFICE WILL RETURN ORIGINAL DOCUMENTS TO YOU. IF YOU DO NOT ENROLL YOUR SPOUSE OR DEPENDENTS WITHIN 90 DAYS OF YOUR INITIAL ELIGIBILITY OR THE DATE THE PERSON BECAME A NEW DEPENDENT, THEY WILL NOT BE ELIGIBLE FOR COVERAGE UNTIL THE 1ST OF THE FOLLOWING MONTH AFTER THE ENROLLMENT FORM AND SUPPORTING DOCUMENTS ARE RECEIVED. IF AN EMPLOYEE/RETIREE ENROLLS A NEWBORN WITHIN 120 DAYS OF THE CHILD'S BIRTH, COVERAGE IS EFFECTIVE AS OF THE DATE OF BIRTH. 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 AND REGULATIONS ADOPTED BY THE BOARD OF TRUSTEES. PLEASE SEE SUMMARY PLAN DESCRIPTION FOR FULL EXPLANATION.

## SPOUSE INFORMATION AND COORDINATION OF BENEFITS

| LAST NAME | FIRST NAME | MI | GENDER | BIRTH DATE | SOCIAL SECURITY NO. |
|---|---|---|---|---|---|
| | | | | | |

| EMPLOYER NAME | EMPLOYER ADDRESS | EMPLOYER PHONE NO. |
|---|---|---|
| | | |

ARE YOU COVERED BY ANOTHER INSURANCE PLAN? YES___ NO___ IF YES, PROVIDE NAME OF INSURANCE PLAN: ________________________________
MEDICAL___ DENTAL ___ EFFECTIVE DATE OF INSURANCE POLICY:__________________ POLICY # ________________ GROUP OR ID#:_______________
IF COVERED BY MEDICARE, PROVIDE HICN NO. ______________________________________

**(ATTACH COPY OF INSURANCE CARD)**

## DEPENDENT INFORMATION AND COORDINATION OF BENEFITS

| NAME (LAST, FIRST, MI) | SOCIAL SECURITY NO. | DATE OF BIRTH | GENDER | RELATIONSHIP TO EMPLOYEE |
|---|---|---|---|---|
| | | | | |

ADDRESS IF DIFFERENT THAN EMPLOYEE'S:

ARE YOU COVERED BY ANOTHER INSURANCE PLAN? YES___ NO___ IF YES, PROVIDE NAME OF INSURANCE PLAN: ________________________________
MEDICAL___ DENTAL ___ EFFECTIVE DATE OF INSURANCE POLICY:__________________ POLICY # ________________ GROUP OR ID#:_______________
IF COVERED BY MEDICARE, PROVIDE HICN NO. ______________________________________

**(ATTACH COPY OF INSURANCE CARD)**

## DEPENDENT INFORMATION AND COORDINATION OF BENEFITS

| NAME (LAST, FIRST, MI) | SOCIAL SECURITY NO. | DATE OF BIRTH | GENDER | RELATIONSHIP TO EMPLOYEE |
|---|---|---|---|---|
| | | | | |

ADDRESS IF DIFFERENT THAN EMPLOYEE'S:

ARE YOU COVERED BY ANOTHER INSURANCE PLAN? YES___ NO___ IF YES, PROVIDE NAME OF INSURANCE PLAN: ________________________________
MEDICAL___ DENTAL ___ EFFECTIVE DATE OF INSURANCE POLICY:__________________ POLICY # ________________ GROUP OR ID#:_______________
IF COVERED BY MEDICARE, PROVIDE HICN NO. ______________________________________

**(ATTACH COPY OF INSURANCE CARD)**

## DEPENDENT INFORMATION AND COORDINATION OF BENEFITS

| NAME (LAST, FIRST, MI) | SOCIAL SECURITY NO. | DATE OF BIRTH | GENDER | RELATIONSHIP TO EMPLOYEE |
|---|---|---|---|---|
| | | | | |

ADDRESS IF DIFFERENT THAN EMPLOYEE'S:

ARE YOU COVERED BY ANOTHER INSURANCE PLAN? YES___ NO___ IF YES, PROVIDE NAME OF INSURANCE PLAN: ________________________________
MEDICAL___ DENTAL ___ EFFECTIVE DATE OF INSURANCE POLICY:__________________ POLICY # ________________ GROUP OR ID#:_______________
IF COVERED BY MEDICARE, PROVIDE HICN NO. ______________________________________

**(ATTACH COPY OF INSURANCE CARD)**

## DEPENDENT INFORMATION AND COORDINATION OF BENEFITS

| NAME (LAST, FIRST, MI) | SOCIAL SECURITY NO. | DATE OF BIRTH | GENDER | RELATIONSHIP TO EMPLOYEE |
|---|---|---|---|---|
| | | | | |

ADDRESS IF DIFFERENT THAN EMPLOYEE'S:

ARE YOU COVERED BY ANOTHER INSURANCE PLAN? YES___ NO___ IF YES, PROVIDE NAME OF INSURANCE PLAN: ________________________________

MEDICAL___ DENTAL ___ EFFECTIVE DATE OF INSURANCE POLICY:__________________ POLICY # ________________ GROUP OR ID#:_______________

IF COVERED BY MEDICARE, PROVIDE HICN NO. _______________________________________

**(ATTACH COPY OF INSURANCE CARD)**

## DEPENDENT INFORMATION AND COORDINATION OF BENEFITS

| NAME (LAST, FIRST, MI) | SOCIAL SECURITY NO. | DATE OF BIRTH | GENDER | RELATIONSHIP TO EMPLOYEE |
|---|---|---|---|---|
| | | | | |

ADDRESS IF DIFFERENT THAN EMPLOYEE'S:

ARE YOU COVERED BY ANOTHER INSURANCE PLAN? YES___ NO___ IF YES, PROVIDE NAME OF INSURANCE PLAN: ________________________________

MEDICAL___ DENTAL ___ EFFECTIVE DATE OF INSURANCE POLICY:__________________ POLICY # ________________ GROUP OR ID#:_______________

IF COVERED BY MEDICARE, PROVIDE HICN NO. _______________________________________

**(ATTACH COPY OF INSURANCE CARD)**

## NOTICE OF CHANGE OF MARITAL STATUS

IF YOU ARE RECENTLY DIVORCED AND NEED TO REMOVE YOUR SPOUSE FROM THE PLAN, PLEASE COMPLETE THE INFORMATION BELOW AND ATTACH A COPY OF YOUR DIVORCE DECREE WITH THE ENROLLMENT FORM AND RETURN TO THE FUND OFFICE.

| LAST NAME | FIRST NAME | SOCIAL SECURITY NO. | DATE OF BIRTH |
|---|---|---|---|
| | | | |

## 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 ENROLLMENT FORM.

## AUTHORIZATION TO RELEASE INFORMATION & 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.

**SIGNATURE OF EMPLOYEE:**__________________________________________________________________**DATE:** ____________________________

## DESIGNATION OF BENEFICIARY FOR DEATH BENEFIT

YOU MAY ELECT MORE THAN ONE PRIMARY BENEFICIARY. A SECOND BENEFICIARY WOULD ONLY APPLY IN THE EVENT THAT THE PRIMARY BENEFICIARY IS NOT LIVING.

| NAME (FIRST, LAST, MI) | DATE OF BIRTH | NAME (FIRST, LAST, MI) | DATE OF BIRTH |
|---|---|---|---|
| RELATIONSHIP TO EMPLOYEE | SOCIAL SECURITY NO. | RELATIONSHIP TO EMPLOYEE | SOCIAL SECURITY NO. |
| ADDRESS IF DIFFERENT THAN EMPLOYEE'S | | ADDRESS IF DIFFERENT THAN EMPLOYEE'S | |
| PRIMARY OR SECONDARY? | | PRIMARY OR SECONDARY? | |

| NAME (FIRST, LAST, MI) | DATE OF BIRTH | NAME (FIRST, LAST, MI) | DATE OF BIRTH |
|---|---|---|---|
| RELATIONSHIP TO EMPLOYEE | SOCIAL SECURITY NO. | RELATIONSHIP TO EMPLOYEE | SOCIAL SECURITY NO. |
| ADDRESS IF DIFFERENT THAN EMPLOYEE'S | | ADDRESS IF DIFFERENT THAN EMPLOYEE'S | |
| PRIMARY OR SECONDARY? | | PRIMARY OR SECONDARY? | |

I HEREBY DESIGNATE THE PERSON(S) OR ENTITY(IES) NOTED ABOVE AS MY BENEFICIARY(IES) TO RECEIVE THE DEATH BENEFIT, IF ANY, PAYABLE AT MY DEATH.

**SIGNATURE OF EMPLOYEE:**______________________________________________________________**DATE:**_____________________