New Member Enrollment/Change Form

I. MEMBER INFORMATION

_____ _____/_____/_____ _____-_____-_____
Name of Member (Last) (First) (M.I.) Date of Birth Social Security Number

_____ ( )_____
Street Address City State Zip Code Telephone #

_____
Local Number Employer

☐ Check if this is a new mailing address Email Address: _____
☐ Check if this is new email address

Sex: ☐ Male ☐ Female Employment Status: ☐ Retired ☐ Active

Marital Status (check one): ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Date of Marriage: _____/_____/_____ Date of Divorce (if applicable): _____/_____/_____

Name of Spouse's Employer:

_____

☐ **check here if spouse is not employed**

(If children are involved, a copy of the decree is required to determine medical responsibility.)

II. BENEFICIARY INFORMATION

I designate the following Beneficiary (ies) to receive any benefits which may be payable to my designated Beneficiary under the following Plan: Mo-Kan Sheet Metal Workers Welfare Fund.

Beneficiary Information

1. _____ _____ ☐ Primary
Full Name Street Address, City, State, Zip

_____ ( )_____ _____/_____/_____ _____
Social Security Number Phone Number Date of Birth Relationship to member

2. _____ _____ ☐ Primary ☐ Secondary (Select One)
Full Name Street Address, City, State, Zip

_____ ( )_____ _____/_____/_____ _____
Social Security Number Phone Number Date of Birth Relationship to member

3. _____ _____ ☐ Primary ☐ Secondary (Select One)
Full Name Street Address, City, State, Zip

_____ ( )_____ _____/_____/_____ _____
Social Security Number Phone Number Date of Birth Relationship to member

Important Beneficiary Information:

1. Your Beneficiary is the person you, as a covered member, designate to receive benefits from the Fund offices should you die. This person would receive any benefits due from life insurance and the Health and Welfare Fund.
2. The Primary Beneficiary is the person you wish to receive any benefits due first. If more than one Primary Beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries as survive you, unless otherwise provided herein.
3. The Secondary Beneficiary is the person you wish to receive any benefits should all the Primary Beneficiaries be deceased.
4. If you fail to designate a beneficiary, or no designated beneficiary survives you, payment will be made to your Estate, or as otherwise provided in the applicable Plan Document.
5. If the beneficiary named is a minor(s) or is otherwise incapacitated, Guardianship or Conservatorship of the Estate of the minor(s) or incapacitated person must be submitted at the time of claim to release any amount payable to the named beneficiary.
6. If a trust is designated as your beneficiary, our offices will require a copy of the trust document.
7. Please check your beneficiary designation periodically and update your file to reflect your current status (Please note: This information cannot be given out over the phone). The most recent beneficiary designation on file at the time of your death will control.

This Beneficiary Designation supersedes any previous or current Beneficiary Designation on file.

III. SPOUSE / DEPENDENT INFORMATION

Please check appropriate box:

☐ NEW ENROLLMENT: List your spouse plus all eligible dependents and eligible handicapped children. (PLEASE PRINT)

☐ ADD / CHANGE DEPENDENT INFORMATION

IMPORTANT ➔➔➔

Please include a copy of any court document, such as a divorce decree or QMCSO that pertains to medical coverage for your dependent(s).

	Spouse	Dependent	Dependent	Dependent
Last Name				
First Name				
Date of Birth	____/____/____	____/____/____	____/____/____	____/____/____
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Relationship to Member	Spouse	☐ Dependent Child ☐ Step-Child ☐ Guardian Child	☐ Dependent Child ☐ Step-Child ☐ Guardian Child	☐ Dependent Child ☐ Step-Child ☐ Guardian Child
Social Security Number	____--____--____	____--____--____	____--____--____	____--____--____
Address (if different from member)				
Are you employed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, does your employer offer insurance coverage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you have <u>any</u> insurance coverage other than MO-KAN?	<u>Check One</u> ☐ No. Skip to the next dependent. ☐ Yes. Complete the rest of this column.	<u>Check One</u> ☐ No. Skip to the next dependent. ☐ Yes. Complete the rest of this column.	<u>Check One</u> ☐ No. Skip to the next dependent. ☐ Yes. Complete the rest of this column.	<u>Check One</u> ☐ No. Skip to the next dependent. ☐ Yes. Complete the rest of this column.
Name of Other Insurance Carrier				
Effective Date of Policy	____/____/____	____/____/____	____/____/____	____/____/____
Other Insurance Phone Number				
Policyholder's Name, DOB and Relationship to Member				
Policy Number				
Coverage Type	<u>Check all that applies.</u> ☐ Medical ☐ Dental ☐ RX ☐ Vision ☐ HRA ☐ HSA	<u>Check all that applies.</u> ☐ Medical ☐ Dental ☐ RX ☐ Vision	<u>Check all that applies.</u> ☐ Medical ☐ Dental ☐ RX ☐ Vision	<u>Check all that applies.</u> ☐ Medical ☐ Dental ☐ RX ☐ Vision

DECLARATION STATEMENT

I hereby declare under penalty of perjury that the information on this form is correct and complete to the best of my knowledge. If requested by the Fund, I agree to obtain and furnish a copy of any divorce decree, support order or other relevant document. I understand that if any incorrect or misleading information on this form results in a loss to the Fund, the Fund is entitled to recover the amount of such loss from me or by withholding from my future benefits.

Member Signature _____ **DATE** _____
(REQUIRED)

IMPORTANT: Review General Authorization Section IV on Next Page ➡

IV *Health Insurance Portability and Accountability Act of 1996

Important Instructions: *Completion of this form allows us to release your protected health information (PHI) to individual(s) you specify. If you do not complete this form, we cannot disclose the information on anyone other than yourself. NOTE: This does not apply to unemancipated children (children under age 18 in MO and IL).* By completing and signing this form, I am authorizing the Fund to release all health information concerning me for purposes of all usual operations of the Fund including, but not limited to, claim status, questions regarding claim payment, benefits, eligibility, or disability, to the person(s) I have designated. This authorization is intended to be in addition to, and not restrictive of, any other consent or authorization I have given, or may give, to the Fund concerning my health information.

MEMBER: HIPAA GENERAL AUTHORIZATION

Member: _____ Member ID (SSN): _____

Person(s) to whom release can be made: Relationship to Member:

1. _____

2. _____

3. _____

_____ _____ _____

Signature of Member or Personal Representative* Date Expiration Date (Optional)

This Member Authorization will remain in effect for one year after termination of coverage unless otherwise specified above.

SPOUSE: HIPAA GENERAL AUTHORIZATION

Spouse Name: _____

Spouse ID (SSN):_____

Person(s) to whom release can be made and relationship to Spouse.

1. _____

2. _____

3. _____

_____

Signature of Spouse or Personal Representative and Date

_____

Expiration Date (Optional)

This Spousal Authorization will remain in effect for one year after termination of coverage unless otherwise specified above.

DEPENDENTS OVER 18 : HIPAA GENERAL AUTHORIZATION

Dependents Name: _____

Dependents ID (SSN):_____

Person(s) to whom release can be made and relationship to Dependent.

1. _____

2. _____

3. _____

_____

Signature of Dependent or Personal Representative and Date

_____

Expiration Date (Optional)

This Dependents Authorization will remain in effect for one year after termination of coverage unless otherwise specified above.

Important Information Concerning Your Rights:

1. You may revoke this Authorization at any time. However, any revocation will not apply to the extent any action that the Fund may have already taken in reliance upon your Authorization. Your request for revocation must be in writing. A Revocation of Authorization Form is available at the Fund Office and will be provided upon request.
2. We may not condition the provision of treatment, payment, enrollment in health plan, or eligibility for benefits upon your signing this Authorization. However, the Plan cannot release PHI to unauthorized individuals.
3. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal health information privacy laws.
4. You may receive a copy of any signed Authorization received by our office, upon request.
5. You may refuse to sign this Authorization. You have the right to inspect or copy the protected health information to be disclosed under this Authorization.

*If signed by a legally authorized Personal Representative of the member or spouse, you must provide the printed name of the Personal Representative and a description of the Personal Representative's authority to act on behalf of the individual: _____

Please Note: If a Power of Attorney has been signed, please furnish a copy of the Power of Attorney document.