SEATTLE AREA PLUMBING & PIPEFITTING INDUSTRY HEALTH TRUST

MAILING ADDRESS
P.O. Box 88970
Tukwila, WA 98138

PHYSICAL ADDRESS
5200 Southcenter Blvd, Ste #205
Tukwila, WA 98188

PHONE: (206) 694-1374
TOLL FREE: (888) 406-3246
FAX: (206) 788-8398

ACTIVE ENROLLMENT FORM

For currently eligible members, this form is also available by logging into your account at www.ua-benefits-wa.org

Please check all that apply:	☐ Add ☐ Change ☐ Delete
INSTRUCTIONS	**Please read and complete the important information on page two of this form**

The Enrollment Form must be completed in order to enroll you and your dependents, if applicable, for Health coverage. Be sure to complete ALL of the information requested on this Enrollment Form.

Remember, once an election is made, you will not be permitted to change your Plan until the next annual Open Enrollment period (changes effective January 1). Please refer to your Summary Plan Description (SPD) for special enrollment rights outside of Open Enrollment.

TO ADD OR CHANGE COVERAGE FOR DEPENDENTS, THE FOLLOWING DOCUMENTATION IS REQUIRED AND MUST BE MAILED TO THE ADDRESS LISTED ABOVE, ATTENTION: SAPPH ELIGIBILITY DEPARTMENT.

- MARRIAGE / DIVORCE: Mail a copy of the state issued Certificate of Marriage to add your Spouse **or** state issued Divorce Decree papers to remove your Spouse.
- NEW DEPENDENT(S): Mail a copy of the state issued Certified Birth Certificate (within 150 days of birth).
- FOSTER & ADOPTED CHILDREN: Mail a copy of the Court appointed/adoption papers.
- Legal Guardianship: Mail a copy of the documents filed with the Court.
- Provide the Social Security Number of each dependent you enroll. Federal regulations require health plans to report the names and Social Security Numbers of every covered individual to the IRS.

ELIGIBILITY FOR ALL PERSONS LISTED SHALL BE SUBJECT TO ALL PROVISIONS AND LIMITATIONS OF THE GOVERNING PLAN DOCUMENTS AS ADOPTED BY THE BOARD OF TRUSTEES.

Section 1 COVERAGE SELECTION

Medical Plan (select one):

☐ **PPO Plan (Aetna/CVS)** ☐ **Kaiser Permanente HMO Plan**

Section 2 PARTICIPANT/EMPLOYEE INFORMATION

Last Name	First Name	Initial	Gender	**Social Security # (mandatory)**	Union Local
				__ __ __ - __ __ - __ __ __ __	

Mailing Address (Street or P.O. Box)	City	State	Zip Code

Date of Birth	Current Marital Status	Date of Marriage / Divorce
	☐ Divorced ☐ Widowed ☐ Single ☐ Married ☐ Legally Separated	

Cell Phone Number	Home Telephone Number	E-mail Address

Section 3 SPOUSE INFORMATION

Last Name	First Name	Gender	Date of Birth	**Social Security # (mandatory)**
				__ __ __ - __ __ - __ __ __ __

Does your Spouse currently have other insurance? ☐ Yes ☐ No

If yes, name of Spouse Employer's name and insurance company	Employer's Telephone Number

Section 4 MEDICARE ELIGIBILITY

Are you or your spouse eligible to have Medicare coverage?

You	Covered by Medicare? ☐ No ☐ Yes *(indicate coverage types)* ☐ Medicare Part A (Hospital only) ☐ Medicare Parts A and B HICN Number:
Your Spouse Coverage	Covered by Medicare? ☐ No ☐ Yes *(indicate coverage types)* ☐ Medicare Part A (Hospital only) ☐ Medicare Parts A and B HICN Number:
Dependent	Covered by Medicare? ☐ No ☐ Yes *(indicate coverage types)* ☐ Medicare Part A (Hospital only) ☐ Medicare Parts A and B HICN Number:

COMPLETION OF ADDITIONAL SECTIONS AND SIGNATURE(S) REQUIRED ON PAGE TWO

Section 5 DEPENDENT(S) INFORMATION - LIST ALL DEPENDENTS TO BE COVERED

CHILDREN ARE COVERED FROM BIRTH TO AGE 26. Eligible dependent children include your natural children, legally adopted children, stepchildren, foster children and children for whom you have legal guardianship. Children who are disabled and unable to support themselves may be covered past age 26 in certain situations.

Last Name	First Name	Relationship	Gender	Date of Birth	**Social Security # (mandatory)**
Dependent 1					___-__-____
Dependent 2					___-__-____
Dependent 3					___-__-____
Dependent 4					___-__-____

(Please attach a separate sheet with the above information to include more dependents)

Do any of these dependents have other insurance? ☐ Yes ☐ No

If yes, please list name of employer _____

If yes, please list other insurance company name _____

Section 6 DELETE THE FOLLOWING FAMILY MEMBERS

Please list ALL family members you wish to remove from the Plan.

Name	Reason (i.e., divorce, etc.)	Effective Date
Name	Reason (i.e., divorce, etc.)	Effective Date
Name	Reason (i.e., divorce, etc.)	Effective Date

If deletion is due to death, divorce or legal separation, mail supporting documentation (i.e., divorce decree, etc.) to address listed on page 1, attention SAPPH Eligibility Department. Please see attached SMM for dependents who can be removed from coverage.

Section 7 EMPLOYEE LIFE INSURANCE (HEALTH) BENEFICIARY INFORMATION

Total of % amounts must equal 100%

This is to certify that I hereby revoke all former beneficiary designations, if any, and name the following as beneficiary for any death benefit payable under the SEATTLE AREA PLUMBING & PIPEFITTING INDUSTRY HEALTH TRUST.

Beneficiary's Last Name	First Name	Initial	Relationship	Social Security #	%
				___-__-____	
Street Address		City		State	Zip Code
Beneficiary's Last Name	First Name	Initial	Relationship	Social Security #	%
				___-__-____	
Street Address		City		State	Zip Code

SPOUSE'S CONSENT OF LIFE INSURANCE BENEFICIARY: By my signature below, I certify that I am legally married to the participant and authorize the life insurance beneficiary designation. ***(Signature required only if beneficiary shown above is someone other than the spouse.)***

Spouse's Signature:_____ Date:_____

Section 8 ACKNOWLEDGEMENT

I hereby certify that the foregoing statements, including any accompanying statements and/or documents, are true, correct and complete to the best of my knowledge, and hereby further authorize my Provider of service to release any medical or other information necessary to process claims. A photocopy will be considered the same as the original.

_____ _____

Participant's Signature Date

Completion of this Enrollment/Change Form does not constitute a guarantee of benefits. Actual benefits are based on eligibility and Plan provisions in effect at the time of service. Please refer to your Summary Plan Description for eligibility rules and a complete list of benefits.