Plumbers and Pipefitters Medical Fund

BASIC INFORMATION

Participant's Name: _____ Social Security No.: _____

Address: _____ Date of Birth: _____

_____

Telephone No.: _____

Active or Retired?: _____ Date of Retirement: _____

Type of Retirement (Normal, Disability, etc.): _____

CERTIFICATION OF DEPENDENT ELIGIBILITY

Are you seeking coverage under the Plan for any Dependent? ___ Yes ___ No

IF YES, YOU MUST COMPLETE ALL APPLICABLE SECTIONS OF THIS FORM:

▶SPOUSE

Name: _____ Social Security No.:_____

Date of Marriage: _____

Date of Spouse's Birth: _____

▶CHILD(REN) (Biological, adopted, and step-children from birth through age 26, except that temporarily (until December 31, 2013) the Plan will not cover Eligible Dependent Children if they are eligible for their own employer-sponsored health coverage or are eligible for coverage under their spouse's employer-sponsored plan; or from age 27 or older if the child lives with you, receives most of his or her financial support from you and is unable to engage in any substantial gainful activity by reason of any permanent medically determinable physical or mental impairment that began before age 27 while the child was covered under this Plan.)

For each child you are seeking to have covered as a Dependent, provide the following information:

1. Name: _____ Social Security No.: _____

   Address: _____ Date of Birth: _____

   _____

2. Name: _____ Social Security No.: _____

   Address: _____ Date of Birth: _____

   _____

(Continue on the back of the form if necessary for additional children)

The following applies in the case of a dependent child over the age of 18 who is currently covered by the Fund or for whom you are seeking coverage under the Fund:

▶ A dependent child is not eligible for coverage under the Fund if s/he is currently eligible for his/her own employer-sponsored health care plan, or is eligible through his/her spouse's employer-sponsored health care plan. Is your dependent child eligible for his/her own employer-sponsored health care plan, or is eligible through their spouse's employer-sponsored health care plan?

_____YES (If yes, your dependent child is not eligible to enroll in the Plumbers & Pipefitters Medical Plan)
_____NO

YOU MUST ATTACH A COPY OF YOUR MARRIAGE CERTIFICATE, AND EACH CHILD'S BIRTH CERTIFICATE (<u>not necessary if you have previously provided these documents to the Fund Office and there has been no change in a dependent's status</u>).

CERTIFICATION REGARDING SECONDARY INSURANCE COVERAGE

In addition to your coverage under the Plan, are you, your spouse or dependent children covered by another health plan (including Medicare Parts A, B and/or D)? _____ yes _____ no

IF YES, YOU <u>MUST</u> PROVIDE ALL OF THE FOLLOWING INFORMATION REGARDING THE OTHER HEALTH INSURANCE (If multiple coverage exists, please list same information for other coverage on the reverse of this form):

Covered Person's Name: _____ Policy No.: _____

Covered Person's Relationship to You: _____

Name of Other Health Plan: _____

Address of Other Health Plan: _____

Effective Date of Coverage: _____ Is coverage through an Employer or Other Group? ___ yes ___ no

If yes, Name of Employer or Other Group: _____

MEMBER CERTIFICATION

<u>I hereby certify that</u>:

_____ (Initial Here) I will notify the Fund's Plan Administrator in a timely manner if or when any of my dependents over the age of 18 becomes eligible to participate in his/her own employer-sponsored health care plan, including his/her spouse's employer-sponsored coverage, and I understand that such notification will thereby forfeit such dependent's right to continue coverage under the Plan as my Dependent.

_____ (Initial Here) The information contained in this Form is true and correct and I understand that the Trustees are relying on this information and the representations I have made in this Form to provide my Dependent(s) with coverage under the Plan.

_____ (Initial Here) If I fail to submit this completed form annually or as otherwise required by the Fund, I understand that my Dependent's eligibility for benefits may be terminated.

Date: _____ Signature of Member: _____