ARIZONA SHEET METAL TRADE TRUST FUND

2400 WEST DUNLAP, SUITE 250
PHOENIX, AZ 85021

TELEPHONE (602) 249-3582 TOLL FREE (800) 474-3485 FAX (602) 249-3795

ENROLLMENT FORM

THIS FORM MUST BE COMPLETED FULLY UPON **ENTRY** INTO THE PLAN, **AND** IT MAY ALSO BE USED TO SUBMIT ANY UPDATED INFORMATION THROUGHOUT THE YEAR.

✓ ***ENTRY 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, SIGNED AND DATED BY YOU.** 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 AND REQUIRED ATTACHMENTS TO THE FUND OFFICE NOW.

✓ **CHECK ONE:** ☐ ***NEW EMPLOYEE*** ☐ ***ADD SPOUSE*** ☐ ***ADD CHILD*** ☐ ***CHANGE PERSONAL DATA***

EMPLOYEE INFORMATION

LAST NAME:	FIRST NAME:	MI:	☐ M ☐ F	BIRTH DATE / /
ADDRESS	CITY	STATE ZIP		PHONE NO. ( ) -
SOCIAL SECURITY NO.	MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED			LOCAL UNION NO.
IF MEDICARE ELIGIBLE ATTACH A COPY OF YOUR MEDICARE CARD				

SPOUSE INFORMATION

LAST NAME:	FIRST NAME:	MI:	BIRTH DATE: / /	☐ M ☐ F	SOCIAL SECURITY NO.
IS YOUR SPOUSE EMPLOYED? ☐ NO ☐ YES	IF YES – EMPLOYER:	ADDRESS:			TELEPHONE NO.

SPOUSE OTHER INSURANCE INFORMATION

IS YOUR SPOUSE ENROLLED IN ANY OTHER EMPLOYER HEALTH PLAN? ☐YES ☐ NO MEDICARE? ☐YES ☐ NO

IF MEDICARE ELIGIBLE ATTACH A COPY OF MEDICARE CARD

IF YES PLEASE INDICATE TYPE OF COVERAGE: ☐ MEDICAL ☐ DENTAL ☐ VISION

NAME OF INSURANCE _____ GROUP, I.D. OR HICN NUMBER:_____

ADDRESS: _____ PHONE NUMBER (_____)_____

EFFECTIVE DATE OF COVERAGE: _____/_____/_____

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.

(Continued on Reverse Side)

✔ ***YOU MUST ATTACH A COPY OF THE CERTIFIED BIRTH CERTIFICATE (IF NOT PREVIOUSLY SUBMITTED)***
✔ ***SOCIAL SECURITY NUMBERS ARE REQUIRED FOR ALL DEPENDENTS.***

MINOR CHILDREN UNDER AGE 19 - INFORMATION

IF ADDITIONAL SPACE NEEDED ATTACH A SEPARATE SHEET

FULL NAME (LAST, FIRST, MI)	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP TO EMPLOYEE
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)

MINOR CHILDREN - OTHER INSURANCE INFORMATION

ARE ANY CHILDREN COVERED BY OTHER INSURANCE? ☐ YES ☐ NO **IF MEDICARE ELIGIBLE ATTACH A COPY OF MEDICARE CARD**

IF YES, PLEASE INDICATE TYPE OF COVERAGE: ☐ MEDICAL ☐ DENTAL ☐ VISION

IF YES – NAME OF COVERED EMPLOYEE:	SOCIAL SECURITY NO.	EFFECTIVE DATE OF COVERAGE

ADULT CHILDREN AGE 19 TO 26 YEARS - INFORMATION

IF ADDITIONAL SPACE NEEDED ATTACH A SEPARATE SHEET

FULL NAME (LAST, FIRST, MI)	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP TO EMPLOYEE
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)

IS THIS CHILD EMPLOYED?	IS A GROUP HEALTH PLAN OFFERED?	IF YES, IS YOUR CHILD ENROLLED?	INDICATE TYPE OF COVERAGE:
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ MEDICAL ☐ DENTAL

IF THIS CHILD DOES NOT HAVE COVERAGE – WHY NOT? NOT ELIGIBLE UNTIL _____/_____/_____
OTHER: EXPLAIN:

FULL NAME (LAST, FIRST, MI)	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP TO EMPLOYEE
	☐ M ☐ F	/ /	/ /	☐ NATURAL/ADOPTED CHILD ☐ STEP CHILD ☐ OTHER (SPECIFY)

IS THIS CHILD EMPLOYED?	IS A GROUP HEALTH PLAN OFFERED?	IF YES, IS YOUR CHILD ENROLLED?	INDICATE TYPE OF COVERAGE:
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ MEDICAL ☐ DENTAL

IF THIS CHILD DOES NOT HAVE COVERAGE – WHY NOT? NOT ELIGIBLE UNTIL _____/_____/_____
OTHER: EXPLAIN:

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 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.

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. I HERBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER FOR HIS SERVICES AS DESCRIBED HEREON OR IN SUPPLEMENTAL STATEMENTS, NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGES FOR THOSE SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN FORCE UNTIL CANCELLED IN WRITING BY ME.

BENEFICIARY INFORMATION

PLEASE UPDATE YOUR BENEFICIARY INFORMATION. IF ADDITIONAL SPACE NEEDED ATTACH A SEPARATE SHEET

FULL NAME AND ADDRESS (PLEASE PRINT)	RELATIONSHIP	% OF LIFE AND/OR LIFE AND AD&D INSURANCE PROVIDED BY H&W PLAN	% OF PENSION BENEFIT, IF APPLICABLE
NAME: ADDRESS:			

✔ _____ _____ _____
EMPLOYEE SIGNATURE SOCIAL SECURITY NUMBER DATE

REVISED 4/7/14