Plumbers & Pipefitters Trust Funds
3660 Stutz Drive, Suite 101
Canfield, OH 44406
(330) 779-8874
www.ualocal94benefits.org

VITAL INFORMATION FORM

Last: _____ First: _____ Middle: _____

Address/City/State/Zip: _____

Social Security Number: ____-____-____ Date of Birth: ____/____/____ Gender :(*circle one*) Male Female

Marital Status: *(circle one)* Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: _____

Current Status: *(circle one)* Active Retired Disabled COBRA

Telephone Number: (____) _____ Alternate Phone Number: (____) _____

Email Address: _____

Employer_____ Date of Hire: _____

Medicare Claim Number: (including the letter(s) that follows the number)
(This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)

Member # _____ **Spouse #** _____ **Dependent # and Name** _____

DEPENDENTS: - Include Spouse (If additional space is needed, please use second sheet)

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

BENEFICIARY INFORMATION:

NAME	RELATION	BIRTHDAY	S.S. #	ADDRESS/CITY/STATE/ZIP	%
(Primary)		__/__/__	___-__-___		
		__/__/__	___-__-___		
(Secondary)		__/__/__	___-__-___		
		__/__/__	___-__-___		

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

_____ _____

MEMBER SIGNATURE **Date**

(OVER)

OTHER INSURANCE INQUIRY

Please complete this portion of the form if you, your spouse, or any of your dependents have other insurance coverage that you participate in, or if there has been any change in other insurance coverage.

General Information:

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Other Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Phone #: (____) _____

Policy/Group Number: _____

Effective date of coverage: _____ Is insurance active? _____

Termination date if applicable: _____

Coverage is: (*circle one*) Single Family

Children are covered until age: _____

Type of coverage: (*circle all that apply*) Medical Dental Vision Prescription

List covered dependents: _____

_____

Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

Any materials submitted by myself or on behalf of any eligible person that contain a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

I Have No Other Insurance: _____
Initial Here/Sign Below

Member Signature:_____ **Date:** _____

PLUMBERS & PIPEFITTERS LOCAL 94
RETIREMENT PLAN

1-800-733-7709
(330) 779-8874

3660 Stutz Drive, Suite 101
Canfield, Ohio 44406

DEAR PLAN PARTICIPANT:

Please complete this form and return it to our office as soon as possible. This form is very important to you. When completed and signed it will be your beneficiary designation for this local union retirement fund. You may change your beneficiary designation at any time. To do so you must file a new beneficiary form with the Fund Office.

PLEASE PRINT:

NAME_____ **SOC. SEC.#**_____

ADDRESS_____

ZIP CODE_____ **HOME PHONE: (___)**_____**BIRTH DATE**_____

MALE ____ **FEMALE** ____ **MARRIED**____ **SINGLE**____

BENEFICIARY(IES) DESIGNATION:

If the Plan Participant is married and the primary beneficiary listed below is NOT the Plan Participant's spouse, the Plan Participant should contact the Fund Office at the phone number listed above to request the Election To Waive Pre-retirement Survivor Annuity Form. If you complete this Beneficiary Form and elect a Primary Beneficiary other than your spouse without obtaining these additional forms, once you return this beneficiary form to the Fund Office, these waiver forms and notices will automatically be sent.

I designate the individual(s) named below as my primary and contingent beneficiary(ies) of this local pension fund. I revoke all prior beneficiary designations, if any, made by me.

PRIMARY BENEFICIARY: NAME_____

SOC. SEC.#_____ **RELATIONSHIP**_____

ADDRESS_____

CITY_____ **STATE**_____ **ZIP CODE**_____

BIRTHDATE___/___/____

CONTINGENT BENEFICIARY If at the time of your death, your primary beneficiary is also deceased, your named contingent beneficiary would become your beneficiary:

NAME_____ **SSN#**_____
ADDRESS_____
CITY_____**STATE**_____**ZIP CODE**_____
RELATIONSHIP_____**BIRTHDATE**___/___/____
PERCENT _____

(Additional Contingent Beneficiaries may be listed on the reverse side)

NAME_____ **SSN#**_____
ADDRESS_____
CITY_____**STATE**_____**ZIP CODE**_____
RELATIONSHIP_____**BIRTHDATE**___/___/_____
PERCENT _____

NAME_____ **SSN#**_____
ADDRESS_____
CITY_____**STATE**_____**ZIP CODE**_____
RELATIONSHIP_____**BIRTHDATE**___/___/_____
PERCENT _____

_____ _____
Participant Signature **Date**

THE SPOUSAL CONSENT AND ACKNOWLEDGEMENT BELOW MUST BE COMPLETED IF SOME PERSON OTHER THAN THE PARTICIPANT'S SPOUSE IS DESIGNATED ON THE REVERSE SIDE OF THIS BENEFICIRY FORM AS A PRIMARY BENEFICIARY.

SPOUSAL CONSENT AND ACKNOWLEDGEMENT

I irrevocably hereby consent to the distribution of all or part of my spouse's vested interest under the above Plan to a beneficiary or beneficiaries, other than myself, as designated by my spouse on this form. I acknowledge that I understand the effect of such designation and of this consent thereto, namely that, in the event of my spouse's death, I will not be entitled to receive those amounts held under the Plan that are payable pursuant to the designation of this form to a beneficiary or beneficiaries other than myself and that I may not revoke this consent for any reason.

_____ _____ _____
Spouse's Name (print or type) Spouse's Signature Date

The foregoing spousal consent was signed before me, this _____ day of _____, _____.

Witnessed by:

_____
Notary Public

MEDICAL MUTUAL

APPLICATION AND POLICY CHANGE

(PLEASE USE BALL POINT PEN)

ENROLLEE: ☐ POLICY CHANGE ☐ NEW ENROLLEE ☐ COBRA APPLICATION

GROUP NO.: ______

LEVEL OF BENEFITS: ☐ Single ☐ Two Persons ☐ Family ☐ Medicare Supplemental

EMPLOYMENT STATUS: ☐ Active ☐ Retired ☐ COBRA

EMPLOYEE CLOCK NUMBER: | EMPLOYEE DEPT. NO.: | PAYROLL LOCATION:

CHANGES: ☐ Add Dependents due to: ☐ Marriage ☐ Birth ☐ Adoption

☐ Drop Dependents Due To: ☐ Divorce ☐ Death ☐ Other ______

☐ New Name ☐ New Address ☐ Change to Medicare Elig. ☐ Change Coverage ☐ Other ______

DATE OF EVENT — MO. — DAY — YR.

COV. OR CHANGE EFF. DATE — MO. — DAY — YR.

Last Name | First Name | M Initial

Street Address | City | State | Zip | Phone No.

Employee Date of Birth MO. DAY YR. | Sex ☐ M ☐ F | Employee Social Security Number | Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced | Date Married MO. DAY YR.

Employer Company Name | Date of Hire-Full Time MO. DAY YR. | Job Title

Check Coverage Desired: ☐ Health ☐ Drug ☐ Dental ☐ Vision

MEDICARE INFORMATION

Are you covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. ______ Effective Date: ______ ☐ Hemodialysis

Is your spouse covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. ______ Effective Date: ______ ☐ Hemodialysis

OTHER INSURANCE INFORMATION

DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH OR DENTAL COVERAGE? ☐ YES ☐ NO IF YES, COMPLETE THE SECTION BELOW.

NAME OF POLICY HOLDER	NAME AND ADDRESS OF OTHER INSURANCE COMPANY	POLICY NUMBER	EFFECTIVE DATE	COVERAGE TYPES	WORK STATUS	POLICY TYPE
			/ /	☐ Medical ☐ Dental ☐ Hospital Only ☐ Vision ☐ Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family
			/ /	☐ Medical ☐ Dental ☐ Hospital Only ☐ Vision ☐ Prescription Drug	☐ Active ☐ Retired	☐ Single ☐ Family

What date did your most recent health insurance program become effective (check box if no prior/current coverage)? ___/___/___ ☐ No coverage

What date did/will this health insurance program terminate (check box if no prior/current coverage)? ___/___/___

RELATIONSHIP	BIRTHDATE	SEX	LAST NAME (ONLY IF DIFFERENT)	FIRST NAME	SOC. SEC. NO.	OVER AGE DEPENDENT STATUS
Spouse	MO. DAY YR.	☐ M ☐ F				
☐ Child ☐ Adopted ☐ Stepchild ☐ Other[1]		☐ M ☐ F				☐ Full-Time Student ☐ Disabled Medicare Elig.: ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other[1]		☐ M ☐ F				☐ Full-Time Student ☐ Disabled Medicare Elig.: ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other[1]		☐ M ☐ F				☐ Full-Time Student ☐ Disabled Medicare Elig.: ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other[1]		☐ M ☐ F				☐ Full-Time Student ☐ Disabled Medicare Elig.: ☐ Hemodialysis ☐ Disability

1. Legal Documentation (court decree, guardianship papers, etc.) must be attached to this application if relationship is marked other.

I hereby apply to Medical Mutual (MM) for the coverage indicated above. I authorize my employer/organization to deduct from my pay and remit any required contribution for the cost of said coverage. I authorize any medical professional, hospital, clinic, or other medical or medically related facility, government agency, or other person to provide to MM information including copies of records concerning advice, care or treatment provided to me and/or my dependents including, without limitation, information relating to mental illness or use of drugs or alcohol. I understand that the kind of coverage for which I am making application contains coordination of benefits, workers' compensation, and subrogation provisions and acknowledge MM's right to enforce these provisions. I have read the above statements and represent that the information provided is true and complete to the best of my knowledge. I understand that the provision of any false information on this application may result in the termination of my benefits and may subject me to legal action by MM. I understand I must notify MM within 30 days of occurrence of any changes in status. I understand that if I am not actively at work on the date my coverage would otherwise become effective, my insurance will not begin until the day I return to work.

Applicant's Signature ______ Date: ______

I hereby waive coverage under the health insurance program ☐ FOR MYSELF ☐ FOR MYSELF AND FAMILY MEMBERS ☐ FOR FAMILY MEMBERS ONLY ☐ FOR ONLY THE FOLLOWING: ______

I understand that if I decide to enroll or add family members at a later date, I will be required to complete a medical history questionnaire and meet certain medical underwriting requirements before coverage will be offered. I further understand that if I and/or my eligible family members are accepted for enrollment at some future date, I am subject to the pre-existing condition restrictions specified in the contract.

Signature ______ Date: ______

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

Plumbers and Pipefitters Local Union #94
Health & Welfare Fund

3660 Stutz Drive, Suite 101, Canfield, Ohio 44406
Phone: 330-779-8874
Fax: 330-270-0912

I, the undersigned, am a new Participant in the Plumbers & Pipefitters Local 94 Health & Welfare Plan. By my signature below, I now elect immediate initial eligibility in the Plan by use of the negative hours bank option extended to me by the Plan to the following Participant category (place an "**X**" beside the applicable Participant category):

_____ New Apprentice Active Participant

_____ New Non-Apprentice Active Participant

_____ New Apprentice Active Participant Directed into the Plan by the International

NOTE – The Plan does NOT extend negative bank hours to use for initial eligibility to a new non-apprentice Active Participant who is directed into the Plan by the International.

I now elect to use _____ negative bank hours of the total number of the available negative bank hours which the Plan provides to me in my Participant category.

I also acknowledge and agree that these negative bank hours used are to be paid back as the Plan directs, either during my employment or by my direct payment to the Fund. Further, my obligation to repay the negative bank hour amount due is subject to collection proceedings against me should I lose Participant status under the Plan with a negative bank hour amount still due and owing to the Plan.

The Plan reserves all rights under applicable law to act to recover all amounts owed.

_____

Signature

_____

Print Full Name

_____

Date

Instructions for completing the

Authorization for Release of Protected Health Information

There is a section for the Participant/Retiree, Spouse and if applicable, a section for a dependent child(ren) over the age of 18.

Participant Section /Retiree Section

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse) –or-
   If you are not married or **you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself". **Please sign and date below the box.**

Spouse Section

1. Fill in your name and social security number.
2. **If you want to give your spouse (participant/retiree)** authority to inquire about your health information, please enter his/her name and relationship (spouse).
   If you want to give someone other than your spouse authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.), **please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".
3. **Please sign and date form below the box.**

Dependent(s) over the age of 18 Section

1. Fill in your name and social security number.
2. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother).
   If want to give someone other than your parents authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.) **please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".
3. Please sign and date form below the box.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

MEMBER / RETIREE SECTION

I, (print name and social security number) _____ **SSN#**___ ___ ___/___ ___/___ ___ ___ __
authorize the Health Fund (the "Fund"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire upon termination of my enrollment in the Fund, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

HIPAA Contact Person
Plumbers & Pipefitters Trust Funds
3660 Stutz Dr. Suite 101
Canfield, OH 44406
(330) 779-8874
www.ualocal94benefits.org

I understand that my health information that is disclosed pursuant to this authorization may be re-disclosed by the persons I have identified above, and the Fund cannot prevent or protect such re-disclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Member_____ **Date Signed:** _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Member_____ **Date Signed**: _____

SPOUSE SECTION

I, the **Spouse** (**Name, Please Print**) _____, (**Spouse's Social Security #**) _____of the above named member, have also read, understand, and authorize the Fund to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse_____ **Date Signed**: _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Spouse _____ **Date Signed**: _____

DEPENDENT(S) OVER THE AGE OF 18 SECTION

I, the **Dependent Child(ren)** over the age of 18 (**Name, Please Print)**_____,**(Social Security #)** _____have also read, understand, and authorize the Fund to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, except at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent_____ **Date Signed**: _____

OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Dependent _____ **Date Signed**: _____

NOTE: If there is more than one dependent over the age of 18, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Fund Office.

Plumbers & Pipefitters National Pension Fund - Beneficiary Designation

Instructions: Print using ONLY capital letters and using an ink pen. Read and follow Instructions for Completing the Beneficiary Designation Form to ensure that your form is completed properly.

Participant Information:

Social Security Number ___-__-____ (Canada only) Social Insurance Number __________

First Name ______ Middle Name ______ Last Name ______

Jr., Sr., I, etc. ____ Birth Date __/__/____ Phone # (___) ___-____

Mailing Address (Street Address or P.O. Box, as applicable) ______ Sex ○ Male ○ Female

Mailing Address (Apt, Etc.) ______ Local Union# ____

City ______ State __ Zip / Canadian Postal Code ______

PRIMARY BENEFICIARY: I hereby designate the following person(s) as my Primary Beneficiary(ies) to receive benefits, if any, payable at my death. Fill in ALL areas below for each Beneficiary.

First Name ______ Middle Name ______ Last Name ______

Jr., Sr., I, etc. ____ Birth Date __/__/____ Sex ○ Male ○ Female

Social Security Number ___-__-____ Relationship: Select one. If 'Other', define the relationship on the line provided.

○ Spouse ○ Child ○ Other ______

Social Insurance Number __________

Is the Beneficiary's address the same as the Participant's address? ○ Yes ○ No If 'No', complete the address section below.

Address ______

City ______ State ______ Zip/Canadian Postal Code ______

First Name ______ Middle Name ______ Last Name ______

Jr., Sr., I, etc. ____ Birth Date __/__/____ Sex ○ Male ○ Female

Social Security Number ___-__-____ Relationship: Select one. If 'Other', define the relationship on the line provided.

○ Spouse ○ Child ○ Other ______

Social Insurance Number __________

Is the Beneficiary's address the same as the Participant's address? ○ Yes ○ No If 'No', complete the address section below.

Address ______

City ______ State ______ Zip/Canadian Postal Code ______

First Name ______ Middle Name ______ Last Name ______

Jr., Sr., I, etc. ____ Birth Date __/__/____ Sex ○ Male ○ Female

Social Security Number ___-__-____ Relationship: Select one. If 'Other', define the relationship on the line provided.

○ Spouse ○ Child ○ Other ______

Social Insurance Number __________

Is the Beneficiary's address the same as the Participant's address? ○ Yes ○ No If 'No', complete the address section below.

Address ______

City ______ State ______ Zip/Canadian Postal Code ______

Designate Contingent and Successor Beneficiary(ies) on page 2. NOTE: Signature required on page 2.

Plumbers & Pipefitters National Pension Fund - Beneficiary Designation

1217646423

Bar Code No.

CONTINGENT and SUCCESSOR BENEFICIARY: If ALL Primary Beneficiary(ies) do not survive, I designate the following person(s) to be my Contingent Beneficiary(ies) to receive benefits, if any, that become due as a result of my death or that remain payable after the death of all the previously named Primary Beneficiary(ies).

First Name ______ Middle Name ______ Last Name ______

Jr., Sr., I, etc. ______ Birth Date __ / __ / ____ Sex ○ Male ○ Female

Social Security Number ___ - __ - ____

Relationship: Select one. If 'Other', define the relationship on the line provided.

○ Spouse ○ Child ○ Other ______

Social Insurance Number ______

Is the Beneficiary's address the same as the Participant's address? ○ Yes ○ No If 'No', complete the address section below.

Address ______

City ______ State ______ Zip/Canadian Postal Code ______

First Name ______ Middle Name ______ Last Name ______

Jr., Sr., I, etc. ______ Birth Date __ / __ / ____ Sex ○ Male ○ Female

Social Security Number ___ - __ - ____

Relationship: Select one. If 'Other', define the relationship on the line provided.

○ Spouse ○ Child ○ Other ______

Social Insurance Number ______

Is the Beneficiary's address the same as the Participant's address? ○ Yes ○ No If 'No', complete the address section below.

Address ______

City ______ State ______ Zip/Canadian Postal Code ______

First Name ______ Middle Name ______ Last Name ______

Jr., Sr., I, etc. ______ Birth Date __ / __ / ____ Sex ○ Male ○ Female

Social Security Number ___ - __ - ____

Relationship: Select one. If 'Other', define the relationship on the line provided.

○ Spouse ○ Child ○ Other ______

Social Insurance Number ______

Is the Beneficiary's address the same as the Participant's address? ○ Yes ○ No If 'No', complete the address section below.

Address ______

City ______ State ______ Zip/Canadian Postal Code ______

I understand that I may change this Beneficiary Designation at any time by filing a new Beneficiary Designation Form with the Fund Office. However, I also understand that, in accordance with the Retirement Equity Act of 1984, if I am married when I retire, my spouse must give written consent to my designation of beneficiaries. Note: If you are already retired and Spousal Consent is needed in order to accept your form, the Fund Office will provide you with the additional forms as needed in order to complete your designation.

______ __ / __ / ____

Signature Date:

You must sign and date the form in order for your designation to be accepted by the Fund Office.