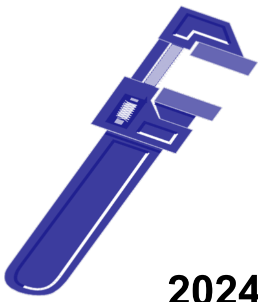

U. A. Local 447 Pipe Trades Benefit Plans

P.O. Box 191030
Sacramento, CA 95819-1030
Ph: 916-457-0821 Fax: 916-457-8276
Toll Free: 1-877-811-4474

5841 Newman Court
Sacramento, CA 95819
Website: www.pipetradesbenefits.org
Email: inquire@447ptb.org

2024 ACTIVE HEALTH & WELFARE ENROLLMENT FORM

UA LOCAL 447 MEMBER'S PERSONAL INFORMATION

LAST NAME:	FIRST NAME:	M.I.:

SOCIAL SECURITY NUMBER:	DATE OF BIRTH:

MAILING ADDRESS:

CITY:	STATE/ZIP

MEMBER'S PRIMARY LINE:	☐ Home ☐ Cell ☐ Work	SECONDARY LINE:	☐ Cell ☐ Work ☐ Spouse

EMAIL ADDRESS:

MARITAL STATUS:
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

CHOOSE A HEALTH PLAN

☐ **U. A. Local 447 Self Funded PPO Medical Plan (Blue Shield of California PPO Network)**

☐ **Kaiser Permanente – Not available outside of California (Kaiser does not cover Foster children)**

FAMILY INFORMATION

Please list all eligible family members to be enrolled. (For additional dependents, please add to a separate piece of paper.)

	LAST NAME, FIRST NAME, MI	ADDRESS, CITY, STATE, ZIP	DATE OF BIRTH	SOCIAL SECURITY #
☐ SPOUSE ☐ Male ☐ Female				
☐ SON ☐ DAUGHTER				
☐ SON ☐ DAUGHTER				
☐ SON ☐ DAUGHTER				
☐ SON ☐ DAUGHTER				
☐ SON ☐ DAUGHTER				

TURN OVER --->

DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? If yes, please complete.				
Other Group Coverage Information:	**Name of other coverage:**	**Effective Date:**	**Termination Date:**	**Name and Date of Birth of Subscriber:**
Member Name:				
Spouse Name:				
Dependent Name:				
Dependent Name:				

ADDITIONAL DEPENDENT INFORMATION

If you are divorced or legally separated, the Plan of the parent with custody pays first. If your child is living with a former spouse, does the former spouse or stepparent have other coverage? ☐ YES ☐ NO

***The plan may require you to provide a copy of your divorce decree to determine correct benefit payments.**

If you acquire a new dependent (as a result of adoption, childbirth or marriage), or you lose a dependent (due to death, divorce, or loss of eligibility status), you should notify the Trust Fund Administration Office within 30 days.

In order to determine eligibility for your spouse and dependent children, the Plan requires that you **submit proof of marriage and copies of birth certificates for your dependent children**. The plan will be unable to provide coverage for your spouse and/or dependent children without this documentation. Failure to provide the required documentation **within 30 days of acquisition (i.e., within 30 days of marriage, birth, adoption or placement for adoption)** will result in a delay of coverage until the next annual open enrollment date in December. Dependents are not considered enrolled in the Health Plan until all completed Enrollment Forms and required marriage or birth certificates are submitted to the Trust Fund Office.

PLEASE NOTE: *if you attempt to claim benefits from the Plan for someone who is not eligible you will be in violation of the law and subject to penalty. Failure to provide U.A. Local 447 Trust Funds with material information (such as divorce) is considered a false statement and you may be subject to suspension of your Health & Welfare benefits for a period of 12 months and/or the duration of the time necessary to recover the amount of erroneous benefit payments made in reliance upon the false statement. The Trustees reserve the right to obtain documents such as birth certificates, marriage licenses, adoption papers, divorce papers, and income tax returns.*

Contact Permission: The U.A. Local 447 Trust Fund would like to send you notices and the latest information on your benefits by email periodically. If you would like to receive this information via email, please check the 'Opt In' box below. If you would like the information to continue to be mailed to you, please check the 'Opt Out' box below.

☐ **Opt In** (To receive information by email and/or mail.)

☐ **Opt Out** (To receive information by mail only.)

I certify under penalty of perjury that all of the above statements are true and correct. I understand that the Board of Trustees has the right to recover any benefits paid on me, or my dependents behalf if they no longer meet the Plan's definition of a dependent, because of a false statement.

____

Participant Signature **Date**