2024 ANNUAL ENROLLMENT / DEMOGRAPHIC INFORMATION REQUEST

FOR MEMBER AND / OR DEPENDENT(S)

TOLL FREE NUMBER
866.236.3148
LOCAL AREA NUMBER
713.643.9300

RETURN COMPLETED INFORMATION TO: →

PIPE FITTERS LOCAL 211
WELFARE TRUST FUND
P.O. Box 87549
Houston Texas 77287

This form must be completed and signed by the Member & Spouse before any claims will be processed.
All questions must be answered.

SECTION ONE - MEMBER INFORMATION ❑ ***Check here if Change of Address***

Name	Street Address City State Zip		
Date of Birth	Social Security Number	Home Phone Number	Local Union #
Email Address:			
Do you consent to receive information by email?	□ Yes □ No		
Marital Status □ Single □ Married □ Divorced □Widowed If applicable: Date of marriage: Date of divorce:			

SECTION TWO - SPOUSE INFORMATION *SPOUSAL AFFIDAVIT REQUIRED

Spouse's Name	Mailing Address □ Check if same as above		
Date of Birth	Social Security Number	Sex: □ Male □ Female	
Is Spouse covered under any other Dental, Vision or Group Health Plan? If Yes, you must complete Section 3 (Other Insurance Information, below) Check all that apply: □Dental □ Vision □ Medical			□ Yes □ No
Are you, your spouse or any eligible dependent(s) covered under Medicare? □ Yes □ No If Yes, who is covered by Medicare? Effective Date of Medicare:			

SECTION THREE - OTHER INSURANCE INFORMATION

Name of Insured	Insured's ID Number:
Policy or Plan No. Type of Coverage: □ Individual □ Family Name, Address and Phone No. of Insurance Company:	
I HEREBY DESIGNATE THE INDIVIDUAL NOTED BELOW TO RECEIVE ANY LIFE INSURANCE BENEFIT PAYABLE UNDER THE PIPE FITTERS LOCAL 211 WELFARE TRUST FUND:	
Full Name	Relationship
Address (If not the same as yours)	

THIS FORM MUST BE DATED AND SIGNED BY YOU AND YOUR SPOUSE

I/WE jointly certify that the information above and on the back of this form is complete, true, and correct. I/WE hereby authorize all doctors, pharmacists, hospitals, or other Institutions rendering care and treatment to furnish **Pipe Fitters Local 211 Welfare Trust Fund** with full information regarding treatment rendered (including copies of their records). I/WE also authorize any union, trust fund, employer or insurance carrier to furnish Pipe **Fitters Local 211 Welfare Trust Fund** with information regarding benefits to which I/WE may be entitled. A copy or photocopy of this authorization shall be considered as effective and valid as the original.

Date	MEMBER'S SIGNATURE	SPOUSE'S SIGNATURE

Please provide the requested information, on the back of this form, on all family members who are covered under the Plan. Please make a copy of the back of this form if more than three dependents.

Dependent's Name	Date of Birth	Social Security Number	Sex: ❑ Male ❑ Female
Dependent's Address			
Relationship to Member: ❑ Child ❑ Step-Child (for whose health coverage You or your eligible spouse is responsible) ❑ Foster Child or other Child of whom you are the legal guardian	Is dependent **eligible** for Health coverage through an employer (other than the employer of the dependent's parent) even if not enrolled in that coverage? ❑ Yes ❑ No If age 26 or older, then dependent is not eligible to participate in the Welfare Trust unless dependent is (i) unable to support himself because of a disability that occurred before his 26th birthday, and (ii) has never married, and (iii) is otherwise eligible under the terms of the Plan.		
Dependent lives with: _____ Has Child ever been married? ❑ Yes ❑ No If yes, date of marriage _____	Is dependent **covered** under any other Dental, Vision or Health Plan? ❑ Yes ❑ No Check all that apply: ❑ Dental ❑ Vision ❑ Medical If yes, you must complete the following: Name of Insured		Group or Plan No.
Is dependent incapable of self-support due to a disability? ❑ Yes ❑ No	Insured's ID No.		Type of Coverage ❑ Family ❑ Individual
	Name, address, & phone number of Insurance Company:		

Dependent's Name	Date of Birth	Social Security Number	Sex: ❑ Male ❑ Female
Dependent's Address			
Relationship to Member: ❑ Child ❑ Step-Child (for whose health coverage You or your eligible spouse is responsible) ❑ Foster Child or other Child of whom you are the legal guardian	Is dependent **eligible** for Health coverage through an employer (other than the employer of the dependent's parent) even if not enrolled in that coverage? ❑ Yes ❑ No If age 26 or older, then dependent is not eligible to participate in the Welfare Trust unless dependent is (i) unable to support himself because of a disability that occurred before his 26th birthday, and (ii) has never married, and (iii) is otherwise eligible under the terms of the Plan.		
Dependent lives with: _____ Has Child ever been married? ❑ Yes ❑ No If yes, date of marriage _____	Is dependent **covered** under any other Dental, Vision or Health Plan? ❑ Yes ❑ No Check all that apply: ❑ Dental ❑ Vision ❑ Medical If yes, you must complete the following: Name of Insured		Group or Plan No.
Is dependent incapable of self-support due to a disability? ❑ Yes ❑ No	Insured's ID No.		Type of Coverage ❑ Family ❑ Individual
	Name, address, & phone number of Insurance Company:		

Dependent's Name	Date of Birth	Social Security Number	Sex: ❑ Male ❑ Female
Dependent's Address			
Relationship to Member: ❑ Child ❑ Step Child (for whose health coverage You or your eligible spouse is responsible) ❑ Foster Child or other Child of whom you are the legal guardian	Is dependent **eligible** for Health coverage through an employer (other than the employer of the dependent's parent) even if not enrolled in that coverage? ❑ Yes ❑ No If age 26 or older, then dependent is not eligible to participate in the Welfare Trust unless dependent is (i) unable to support himself because of a disability that occurred before his 26th birthday, and (ii) has never married, and (iii) is otherwise eligible under the terms of the Plan.		
Dependent lives with: _____ Has Child ever been married? ❑ Yes ❑ No If yes, date of marriage _____	Is dependent **covered** under any other Dental, Vision or Health Plan? ❑ Yes ❑ No Check all that apply: ❑ Dental ❑ Vision ❑ Medical If yes, you must complete the following: Name of Insured		Group or Plan No.
Is dependent incapable of self-support due to a disability? ❑ Yes ❑ No	Insured's ID No.		Type of Coverage ❑ Family ❑ Individual
	Name, address, & phone number of Insurance Company:		

Note: It may constitute fraud and/or grounds for immediate and retroactive termination of coverage to: (i) provide inaccurate or incomplete information on this form, (ii) enroll an ineligible spouse or dependent, or (iii) fail to contact the Welfare Trust once your spouse or dependent is no longer eligible to participate in the Welfare Trust Fund.

You must provide any documentation that the Welfare Trust Fund reasonably requires in order to substantiate that your spouse, child, or other dependent is eligible to participate in the Welfare Trust. Fund If you have questions regarding the eligibility of your spouse, child, or other dependent, contact the Welfare Trust Fund at (713) 643-9300 or (866) 236-3148.

Spousal Affidavit – Must be completed by Spouse

As the legal spouse of a Pipe Fitters Local 211 Trust Fund participant, in order to be covered under the medical plan during plan year starting January 1, 2024 you must sign and return this Spousal Affidavit with your spouse annual demographics form.

Please check the appropriate box below and certify that I am:

- ❑ I am not employed or I am Retired with no ability to obtain insurance coverage
- ❑ I am Self-employed with no ability to obtain insurance benefits
- ❑ I am Employed but my employer does not offer group health plan coverage. You must provide proof from your employer.
- ❑ I am enrolled in group health plan coverage through my employer.
  If you check this box, please provide the information requested below.

I also certify under penalty of perjury under the laws of the State of Texas that the foregoing is true and correct. I understand that providing false information or concealing important facts can be considered a violation of the law and punishable by a fine, imprisonment, or both and that I may be required to repay to the Plan any benefits improperly paid on my behalf.

Spouse Name (Please print): _____

Spouse Signature: _____ Date _____

Member Name (Please print):_____

Member Signature: _____ Date _____

If you have any questions about spousal eligibility status, contact Benefit Resources Inc. before signing this document. Please note:

- *The Plan reserves the right to request at any time documentation that substantiates the eligibility of an enrolled spouse.*
- *The Plan has the right to request reimbursement of any premiums and claims paid for ineligible spouses.*
- *Failure to complete this Spousal Affidavit fully and truthfully will make the spouse ineligible for Trust Fund health plan coverage during 2024*

Complete if You Have Health Plan Coverage through Your Employer

If you are enrolled in group health plan coverage through your employer, please provide the following information:

Employer Name: _____

Insurance Company: _____

Group Number and ID Number_____

Effective Date: _____