NEW MEMBER ENROLLMENT FORM

P.O. Box 300019 Kansas City, MO 64130
P#: (816) 531 0334   F#: (816) 753 7252

I. MEMBER INFORMATION |

SOCIAL SECURITY NUMBER | LAST NAME | FIRST NAME | MI | DATE OF BIRTH | PHONE NUMBER

STREET ADDRESS | APT # | CITY | STATE | ZIP CODE | EMAIL ADDRESS

EMPLOYER | LOCAL UNION NUMBER

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LEGALLY SEPARATED

II. SPOUSE / MARITAL INFORMATION |

DATE OF MARRIAGE | LAST NAME | FIRST NAME | MI | DATE OF BIRTH | SOCIAL SECURITY NUMBER

PHONE NUMBER | EMAIL ADDRESS

EMPLOYMENT STATUS: ☐ WORKING ☐ NOT WORKING ☐ RETIRED ☐ SSDI

III. BENEFICIARY INFORMATION |

☐ **PRIMARY**
☐ **SECONDARY**

LAST NAME | FIRST NAME | MI | DATE OF BIRTH | PHONE NUMBER

SOCIAL SECURITY NUMBER | RELATIONSHIP TO MEMBER | STREET ADDRESS | APT # | CITY | STATE | ZIP CODE

☐ **PRIMARY**
☐ **SECONDARY**

LAST NAME | FIRST NAME | MI | DATE OF BIRTH | PHONE NUMBER

SOCIAL SECURITY NUMBER | RELATIONSHIP TO MEMBER | STREET ADDRESS | APT # | CITY | STATE | ZIP CODE

☐ **PRIMARY**
☐ **SECONDARY**

LAST NAME | FIRST NAME | MI | DATE OF BIRTH | PHONE NUMBER

SOCIAL SECURITY NUMBER | RELATIONSHIP TO MEMBER | STREET ADDRESS | APT # | CITY | STATE | ZIP CODE

IMPORTANT BENEFICIARY INFORMATION:

- Your Beneficiary is the person you, as a covered member, designate to receive benefits from the Fund offices should you die. This person would receive any benefits due from life insurance and the Health and Welfare Fund
- The Primary Beneficiary is the person you wish to receive any benefits due first. If more than one Primary Beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries as survive you, unless otherwise provided herein
- The Secondary beneficiary is the person you wish to receive any benefits should all the Primary Beneficiaries be deceased.
- If you fail to designate a beneficiary, or no designated beneficiary survives you, payment will be made to your estate, or as otherwise provided in the applicable Plan Document.
- If the beneficiary named is a minor(s) or is otherwise incapacitated, Guardianship of Conservatorship of the Estate of the minor(s) or incapacitated person must be submitted at the time of claim to release any amount payable to the named beneficiary.
- If a trust is designated as your beneficiary, our offices will require a copy of the trust document
- Please check your beneficiary designation periodically and update your file to reflect your current status (**Please Note**: This information cannot be given out over the phone). The most recent beneficiary designation on file at the time of your death will control.

This Beneficiary Designation supersedes any previous or current Beneficiary Designation on file.

(REQUIRED)
Member Signature:____**Date:**______________________________________

IV. DEPENDENT INFORMATION | PLEASE INCLUDE SUPPORTING DOCUMENTS RELEVANT TO MEDICAL RESPONSIBILITY FOR YOUR DEPENDENTS

☐ **PLEASE CHECK HERE IF YOU HAVE NO DEPENDENTS**

	SPOUSE	DEPENDENT	DEPENDENT	DEPENDENT
LAST NAME				
FIRST NAME				
DATE OF BIRTH	/ /	/ /	/ /	/ /
SEX	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
RELATIONSHIP TO MEMBER	Spouse	☐ Dependent Child ☐ Stepchild ☐ Guardian Child	☐ Dependent Child ☐ Stepchild ☐ Guardian Child	☐ Dependent Child ☐ Stepchild ☐ Guardian Child
SOCIAL SECURITY NUMBER	- -	- -	- -	- -
ADDRESS IF DIFFERENT FROM SUBSCRIBER ADDRESS				
ARE YOU EMPLOYED	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
EMPLOYER NAME				
IS INSURANCE COVERAGE OFFERED	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DO YOU HAVE OTHER COVERAGE	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
INSURANCE CARRIER				
EFFECTIVE DATE OF POLICY	/ /	/ /	/ /	/ /
INSURANCE PHONE NUMBER				
NAME AND RELATIONSHIP TO SUBSCRIBER				
SUBSCRIBER'S DATE OF BIRTH	/ /	/ /	/ /	/ /
POLICY NUMBER				
GROUP NUMBER				
COVERAGE TYPE	Check ALL that apply ☐Medical ☐RX ☐Dental ☐Vision ☐HRA ☐HSA	Check ALL that apply ☐Medical ☐RX ☐Dental ☐Vision ☐HRA ☐HSA	Check ALL that apply ☐Medical ☐RX ☐Dental ☐Vision ☐HRA ☐HSA	Check ALL that apply ☐Medical ☐RX ☐Dental ☐Vision ☐HRA ☐HSA

VI. DECLARATION STATEMENT |

I hereby declare under penalty of perjury that the information on this form is correct and complete to the best of my knowledge. If requested by the Fund, I agree to obtain and furnish a copy of any divorce decree, support order or other relevant document. I understand that if any incorrect or misleading information on this form results in a loss to the Fund, the Fund is entitled to recover the amount of such loss from me or by withholding from my future benefits

(REQUIRED)

Member Signature:_____ **Date:**_____

VI. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 |

Important Instructions: Completion of this form allows us to release your protected health information to individual(s) you specify. If you do not complete this form, we cannot disclose the information to anyone other than yourself. This does not apply to unemancipated children. By completing and signing this form, I am authorizing the Fund to release all health information concerning me for purposes of all usual operations of the Fund including, but not limited to; claim status, questions regarding claim payment, benefits, eligibility, or disability, to the person(s) I have designated. This authorization is intended to be in addition to, and not restrictive of, any other consent or authorization I have given, or may give, to the Fund concerning my health information.

VII. HIPAA GENERAL AUTHORIZATION |

A. HIPAA General Authorization for Subscriber

Member name:_____ **Member's social security number:**_____

Person(s) to whom release can be made | **Relationship to Member |**

1._____ _____

2._____ _____

3._____ _____

_____ _____ _____
Signature of Member or Personal Representative Date Expiration Date (optional)

This member authorization will remain in effect for one year after termination of coverage unless otherwise specified

B. HIPAA General Authorization for Spouse

Spouse name:_____

Person(s) to whom release can be made |

1._____

2._____

3._____

_____ _____
Signature of Spouse or Personal Representative Date

_____
Expiration Date (optional)

This spousal authorization will remain in effect for one year after termination of coverage unless otherwise specified above.

C. HIPAA General Authorization for Dependents over 18

Dependent Name:_____

Person(s) to whom release can be made |

1._____

2._____

3._____

_____ _____
Signature of Dependent or Personal Representative Date

_____
Expiration Date (optional)

This dependent authorization will remain in effect for one year after termination of coverage unless otherwise specified above.

IMPORTANT INFORMATION CONCERNING YOUR RIGHTS:

- You may revoke this Authorization at any time. However, any revocation will not apply to the extent any action that the Fund may have already taken in reliance upon your Authorization. Your request for revocation must be in writing. A Revocation of Authorization Form is available at the Fund Office and will be provided upon request.
- We may not condition the provision of treatment, payment, enrollment in health plan, or eligibility for benefits upon your signing this Authorization. However, the Plan cannot release PHI to unauthorized individuals.
- Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal health information privacy laws.
- You may receive a copy of any signed Authorization received by our office, upon request.
- You may refuse to sign this Authorization. You have the right to inspect or copy the protected health information to be disclosed under this Authorization.

* If signed by a legally authorized Personal Representative of the member or spouse, you must provide the printed name of the Personal Representative and a description of the Personal Representative's authority to act on behalf of the individual:

Please Note: If a Power of Attorney has been signed, please furnish a copy of the Power of Attorney document.