PLUMBERS & FITTERS LOCAL UNION No. 295 HEALTH & WELFARE FUND

2026

Annual Participant Verification Form

IMPORTANT NOTICE

This form must be filed with the Fund Office on an annual basis. If the Fund Office receives claim(s) for you and/or your dependents and this form is not on file for the Calendar Year in which the claim(s) were incurred, your claim(s) will be denied pending receipt of this form by the Fund Office. If you submit this form within 12 months from the date of service, your claim(s) will be reprocessed. If you do not submit the form within 12 months from the date of service, your claim(s) will remain denied and the provider will be able to bill you for services rendered.

Employee Full Name:		**Social Security #:**	
		Date of Birth:	
Employee Mailing Address:		**Home Phone #:**	
		Cell Phone #:	
Do you have other coverage (this includes Medicare or Medicaid):	(Circle One) YES NO		
If yes, to the above – please provide the name of the carrier, phone number, effective date and your policy number or identification number in the space below:			

HEALTH PLAN - THIS SECTION MUST BE COMPLETED TO ENROLL YOUR SPOUSE AND/OR CHILD(REN) IN THE HEALTH PLAN.

Full Name of Spouse* *Include a copy of your marriage certificate if you are a new employee or if you recently married/remarried. Also must include a copy of spouse's birth certificate and social security card when enrolling the first time.	**Date of Birth**	**Social Security Number**	**Does your spouse have other Medical coverage?**	**If your spouse has other Medical coverage (this includes Medicare or Medicaid), please provide the requested information below.**	
			YES NO Please circle your response	Insurance Carrier Name:	Coverage Effective Date:
				Insurance Carrier Phone #:	Policy Identification #:

Full Name of Child(ren)** **Include a copy of the divorce, support or paternity decree for any child NOT born of your current marriage or who does NOT live with you. Also must include a copy of each dependent child's birth certificate and social security card when enrolling the first time.	**Date of Birth**	**Social Security Number**	**Does your child(ren) have other Medical coverage?**	**If your child/children have other Medical coverage (this includes Medicare or Medicaid), please provide the requested information below.**		
			YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:
			YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:
			YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:

BENEFICIARY DESIGNATION – YOUR BENEFICIARY WILL RECEIVE ANY DEATH BENEFITS PAYABLE BY THE FUND IN THE EVENT OF YOUR DEATH

Beneficiary's Full Name:	Relationship to You:	Social Security Number:
Address, if Different than Yours:		

DENTAL PLAN - THIS SECTION MUST BE COMPLETED IF YOU ENROLLED YOUR SPOUSE AND/OR CHILD(REN) IN THE HEALTH PLAN (ABOVE).

Full Name of Spouse *Include a copy of your marriage certificate if you are a new employee or if you recently married/remarried.	**Does your spouse have other Dental coverage?**	**If your spouse has other Dental coverage, please provide the requested information below.**	
	YES NO Please circle your response	Insurance Carrier Name:	Coverage Effective Date:
		Insurance Carrier Phone #:	Policy Identification #:

Full Name of Child(ren) **Include a copy of the divorce, support or paternity decree for any child NOT born of your current marriage or who does NOT live with you.	**Does your child(ren) have other Dental coverage?**	**If your child(ren) have other Dental coverage, please provide the requested information below.**		
	YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
		Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:
	YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
		Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:
	YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
		Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:

EMPLOYEE ACKNOWLEDGEMENT & SIGNATURE

I certify that the information provided on this Annual Participant Verification Form is true and correct to the best of my knowledge and that the dependents I have enrolled meet the Plan's definition of a Dependent as defined in the Plan Document and Summary Plan Description (SPD).

I understand that it is my responsibility to notify the Fund Office within 60 days of a divorce or legal separation from my spouse.

Employee Signature: _____ Date: _____

EMPLOYEE & SPOUSE (IF APPLICABLE)

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S): I hereby authorize payment directly to the provider(s) of the surgical, medical and/or prescription benefits, if any, otherwise payable to me for services.	PARTICIPANT/EMPLOYEE SIGNATURE: DATE	SPOUSE SIGNATURE, IF APPLICABLE: DATE
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the provider(s) to release any information acquired in the course of my examination or treatment in order to determine benefit coverage and/or to process claims for payment.	PARTICIPANT/EMPLOYEE SIGNATURE: DATE	SPOUSE SIGNATURE, IF APPLICABLE: DATE

DEPENDENT ADULT-CHILD(REN) - DEPENDENT ADULT-CHILD(REN) MUST COMPLETE IF THEY WILL BE AGE 18 TO 26 ANYTIME DURING THE APPLICABLE YEAR

AUTHORIZATION TO PAY BENEFITS TO PROVIDER(S): I hereby authorize payment directly to the provider(s) of the surgical, medical and/or prescription benefits, if any, otherwise payable to me for services.	1. DEPENDENT ADULT-CHILD NAME (PRINT): DATE	1. DEPENDENT ADULT-CHILD SIGNATURE & DATE: DATE
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the provider(s) to release any information acquired in the course of my examination or treatment in order to determine benefit coverage and/or to process claims for payment.	1. DEPENDENT ADULT-CHILD NAME (PRINT): DATE	1. DEPENDENT ADULT-CHILD SIGNATURE & DATE: DATE
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the provider(s) to release any information acquired in the course of my examination or treatment in order to determine benefit coverage and/or to process claims for payment.	2. DEPENDENT ADULT-CHILD NAME (PRINT): DATE	2. DEPENDENT ADULT-CHILD SIGNATURE & DATE: DATE