PLUMBERS & FITTERS LOCAL UNION #295 HEALTH & WELFARE FUND

Annual Participant Verification Form

Calendar Year: _____

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, you must include a copy of your 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, you 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 #:

CONTINUE ON REVERSE SIDE

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 ("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 (which EXCLUDES coverage of an ex-spouse effective with the date of divorce or legal separation regardless if the participant is required to provide insurance coverage).

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: _____

FUND OFFICE:
NATIONAL EMPLOYEE BENEFITS ADMINISTRATORS, INC. ● 8657 BAYPINE ROAD, BLDG. 5 – STE. 200 • JACKSONVILLE, FL 32256
Phone (904) 538-0100 • Toll Free (888) 396-5899 • Fax (904) 538-0088