Pipe Trades Services MN Non-Collectively Bargained Welfare Enrollment

PTSMN FAX 651-645-8119 PHONE 651-645-4540

To be entered by Local Union Office

(Check One) ☐ **New Participant** ☐ **Updated information for existing Participant**

Employee Information A copy of your Social Security Card MUST be included

PLEASE PRINT CLEARLY

1. ______________________________ Last name First name Middle
2. ______-______-______ Social Security Number
3. ____/____/____ Date of Birth
4. M / F Gender (circle)
5. __________ Local Union #

6. ______________________________ Home address Number Street City State Zip
7. (____)__________ Home Phone
8. __________ Employer Name

Spouse Information A copy of your Marriage Certificate and Social Security Card MUST be included

9. ______________________________ Last name First name Middle Initial
10. ______-______-______ Social Security Number
11. ____/____/____ Date of Birth
12. M / F Gender
13. ____/____/____ Date of Marriage

14. Is your spouse employed? ☐ Yes ☐ No If Yes, Please list below Name, Address, and Phone Number of Employer:

______________________________ (_____)__________

Employer name Employer Address Employer Phone #

Coordination of Benefits (COB)

15. Is your spouse covered under another Insurance Plan? ☐ Yes ☐ No

16. If yes, Check coverage that applies to spouse's plan: ☐Medical ☐Dental ☐Vision ☐ Prescription Drug

17. List Name of spouse's Insurance Plan, Policy Number, and Effective date.

______________________________ ______________________________ ______/______/______

Insurance name Policy Number Policy Effective Date

18. Check spousal coverage that applies to dependent children: ☐ Medical ☐Dental ☐ Vision ☐ Prescription Drug

This plan uses the Birthday Rule to determine which plan is the primary payer for your dependent children's coverage bases on whose birth date comes first in the year yours or your spouses.

(Continued on reverse side)

19. Dependent Children Information (to age 26) A copy of the Birth Certificate and Social Security Card MUST be included for each dependent

First Name	Last Name	Gender (Circle one)	Date of Birth	Social Security Number	Relationship (Son, Daughter, Step-Son)
______	______	M / F	___/___/___	___/___/___	______
______	______	M / F	___/___/___	___/___/___	______
______	______	M / F	___/___/___	___/___/___	______
______	______	M / F	___/___/___	___/___/___	______
______	______	M / F	___/___/___	___/___/___	______
______	______	M / F	___/___/___	___/___/___	______

20. Are any of the dependent children covered through a plan other than listed above? ☐Yes ☐ No

If Yes ______________________ ___/___/___ ______________________ ______________

Policy Holder | Social Security Number | Policy Name | Policy Number

Name of Dependent(s) Covered: ______________________________

21. Is this policy obligated to pay first? ☐Yes ☐No

22. This policy includes: ☐Medical ☐Dental ☐ Vision

I hereby authorize any insurance company, hospital, physician, or employer to release information to the Pipe Trades Services MN with respect to myself or any of my dependents, which may have a bearing on the benefits payable under this plan. I certify that the above information is true and correct to the best of my knowledge.

______________________________________ ___/___/___

Member's Signature | Date

For office use only Date received at Fund office ___/___/___ Effective Date ___/___/___ Entered in Fund Computer System ___/___/___ Coverage Code # ______ Date S PD Mailed ___/___/___