

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. _____ 2. _____ - _____ - _____ 3. ____/____/____ 4. M / F
Last name First name Middle Social Security Number Date of Birth Gender (circle)

5. _____ 6. (____) _____ 7. _____
Home address Number Street City State Zip Home Phone Employer Name

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

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

13. 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)

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

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

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

Insurance name Policy Number _____
Policy Effective Date

17. 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)

18. 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)
_____	_____	<u>M</u> / F	____/____/____	____/____/____	_____
_____	_____	<u>M</u> / F	____/____/____	____/____/____	_____
_____	_____	<u>M</u> / F	____/____/____	____/____/____	_____
_____	_____	<u>M</u> / F	____/____/____	____/____/____	_____
_____	_____	<u>M</u> / F	____/____/____	____/____/____	_____
_____	_____	<u>M</u> / F	____/____/____	____/____/____	_____

19. 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: _____

20. Is this policy obligated to pay first? Yes No

21. 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