Pipe Trades Services MN - Enrollment Form

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

For office use only PTSMN ID_____ ☐Spouse ☐Dependent Child

To be entered by Local Union Office

1.(Check One) ☐New Member ☐Updated information for existing member

2.(Check One) ☐Pre-apprentice ☐Apprentice - If apprentice, CIRCLE program year: 1 2 3 4 5 ☐Journeyman ☐Other

3.Trade Code _____ **4.** Description or Comments_____

5.Local (Circle One) 6 Rochester 15 Mpls 15 St Cloud 15 Gas Distribution 34 St Paul 34 Mankato 455 St Paul 455 Mankato 539 Mpls 539 St Cloud Office Workers Local 12

Employee Information Please provide a copy of your Social Security Card

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 City State Zip Home Phone Cell Phone

8. ☐ I consent to receive selected non-confidential email from PTSMN _____ **9.**_____

Email Address Employer Name

Spouse / Coordination of Benefits Information Please provide a copy of your Certified Marriage Certificate

10._____ **11.**_____-____-_____ **12.**____/____/_____ **13. M / F** **14.**____/____/_____

Last name First name Middle Social Security Number Date of Birth Gender(circle) Date of Marriage

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

_____ (_____)_____

Employer name Employer Address Employer Phone #

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

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

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

_____ _____ _____/_____/_____

Insurance name Policy Number Policy Effective Date

19. 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 based on whose birth date comes first in the year yours or your spouses.

(Continued on reverse side)

Dependent Children Information (to age 26) Please provide a copy of the Birth Certificate

20.

First Name	Last Name	Gender Circle one	Date of Birth	Social Security Number	Relationship(son, daughter, step-child)
		M / F	___/___/___	___/___/___	
		M / F	___/___/___	___/___/___	
		M / F	___/___/___	___/___/___	
		M / F	___/___/___	___/___/___	
		M / F	___/___/___	___/___/___	
		M / F	___/___/___	___/___/___	
		M / F	___/___/___	___/___/___	
		M / F	___/___/___	___/___/___	
		M / F	___/___/___	___/___/___	
		M / F	___/___/___	___/___/___	

21. Are any of the dependent children covered through a plan other than listed above?(Line Item: **18.**) ☐ Yes ☐ No

If Yes:_____ ___/___/___ _____ _____
Policy Holder | Social Security Number | Policy Name | Policy Number

Name of Dependent(s) Covered _____

Is this policy obligated to pay first? ☐ Yes ☐ No
This policy includes: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription Drug

Please Sign Below

I hereby authorize any insurance company, hospital, physician, or employer to release information to the Pipe Trades Services MN with regard to me 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