PIPE TRADES SERVICES MN
HEALTH & PENSION FUNDS
4461 White Bear Parkway, Suite 1 - White Bear Lake, MN 55110 • Phone: 651-645-4540 • Fax: 651-645-8119 • www.PTSMN.org

NON-COLLECTIVELY BARGAINED EMPLOYEE ENROLLMENT FORM

For office use only PTSMN ID_____ Adding: ☐ Spouse ☐ Dependent Child
New Member YES / NO
Updated Information for existing member: YES/ NO

Employee Information - a copy of your birth certificate and social security card MUST be included.				
Last Name	**First Name, Middle Initial**	**Social Security Number**	**Gender (circle one)**	**Date of Birth**
			Male/Female	
Home Address (include unit/apartment number)			**City/State/Zip**	
Phone Numbers		**I consent to receive emails from the Welfare Fund (check one):**		
HOME:		☐ No		
CELL:		☐ Yes Email address:_____		

Your Dependents first become eligible for benefits on the same day that you first become eligible. If a person becomes your Dependent while you are eligible (by birth, marriage, adoption, or otherwise), that person becomes eligible on the day he or she becomes your Dependent if you submit complete and accurate enrollment forms to the Fund Office within 30 days. If you submit enrollment forms more than 30 days after the date the person became your Dependent, your new Dependent will become eligible on the first day of the month following the month in which you submit enrollment forms.

Spouse Information – a copy of your certified marriage certificate, birth certificate and social security card MUST be included.		
Last Name	**First Name, Middle Initial**	**Date of Birth**
Social Security Number	**Gender (circle one)**	**Date of Marriage**
	Male/Female	
Is your Spouse covered under another group health plan/ insurance policy? ☐ Yes ☐ No	If yes, select the types of coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription Drug	Spousal coverage that applies to Dependent children: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription Drug
Spouse Insurance/Plan Name:	Policy Number:	Effective Date of Coverage:

(over)

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 Spouse's.

Dependent Children Information – a copy of each birth certificate and social security card MUST be included.					**For newborns: send enrollment form in within 30 days of birth even if you do not have the required documents. Those documents can be sent in when you receive them at a later date.**
Last Name	**First Name, Middle Initial**	**Social Security Number**	**Date of Birth**	**Gender (M/F)**	**Relationship to Employee (Daughter/Son/Step-Child)**

Are any of the dependent children covered through a plan other than Pipe Trades Services MN?

- ☐ Yes (if yes, please complete table below)
- ☐ No

Plan Covering Dependent Children		
Policy Holder Name	**Policy Holder Date of Birth**	**Plan / Policy Name / Policy Number/Effective Date**
Names of Dependent Children Covered	**Is other coverage obligated to pay first?**	**Coverage the Policy Includes:**
	☐ Yes ☐ No	☐ Medical ☐ Vision ☐ Dental ☐ Prescription Drug

I hereby authorize any insurance company, hospital, physician, or employer to release information to the Pipe Trades Services MN Welfare Fund ("**Welfare Fund**") with regard to me or any of my Dependents, which may relate to the benefits payable under the Welfare Fund.

Important Information

The Pipe Trades Services MN Welfare Fund ("**Welfare Fund**") will rescind (i.e., retroactively terminate) your eligibility (or that of your Dependents) for fraud or an intentional misrepresentation of a material fact. A rescission will be effective back to the date you became eligible, or remained eligible, as a result of the fraud or intentional misrepresentation. If your eligibility is rescinded, you will be provided 30 days' advance written notice and **you will be liable to the Welfare Fund for any benefits you received during the period of rescinded eligibility**, plus interest and all collection expenses the Welfare Fund incurs. The Welfare Fund may take any legal action necessary to collect outstanding amounts due as a result of the rescission, including, without limitation, offsetting any benefits that are owed to you or your Dependents and filing a lawsuit.

☐ **Yes, I certify that the information above is true and correct to the best of my knowledge**

_____ _____/_____/_____

Participant's Signature Date