HEALTH SERVICES AND INSURANCE PLAN __________
ANNUAL INFORMATION REQUEST FOR CALENDAR YEAR 2009

SEE BACK OF FORM FOR ADDITIONAL INFORMATION

Member Name ______________________

Address ______________________

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☐ Please check if address is different

Social Security Number ______________________

Date of Birth ______________________

Telephone Number ______________________

Employer Name ______________________

Member E-Mail

This form must be completed (PLEASE PRINT) and submitted to the Fund Office once each calendar year before health care claims will be processed for the member or any dependent. If you, your spouse and/or children are being added to the Plan, you should also submit any Certificates of Creditable Coverage you have. *Each question must be answered. Attach additional pages if necessary.* ***Any changes in the information on this form should be reported to the Fund Office immediately.***

Marital Status*: ☐ Married ☐ Single ☐ Divorced ☐ Legally separated Date of change, if applicable__________________

**If your marital status has changed during the last calendar year, note the date above and submit a copy of your marriage certificate, divorce decree or order of legal separation.*

Dependents: ***Has a dependent been added or removed during the year?*** ☐ **Yes** ☐ **No** ***If yes, name _______________ and date _____________________. You may be required to submit additional information such as a birth certificate, acknowledgement of paternity, divorce decree, adoption paper, support order or Qualified Medical Child Support Order.***

In this section you must provide information about any other group health benefits you, your spouse and/or your children have.
Does your spouse work? ☐ Yes ☐ No If yes, provide name and address of employer________________________________

Does your spouse have health care benefits available through an employer? ☐ Yes ☐ No Contribution Required? ☐ Yes ☐ No

Do you have benefits under any other group health plan including Medicare or State Programs?

☐ Yes ☐ No If yes, are benefits under ☐ State Program ☐ Medicare Contribution Required? ☐ Yes ☐ No

Do your spouse and/or children have benefits under any other group health plan including Medicare or State Programs?

☐ Yes ☐ No If yes, are benefits under ☐ State Program ☐ Medicare

Print your first and last name and that of your spouse and each dependent child **living with you.** Check boxes for relationship and designation (sp for spouse, ch for child, M for male and F for female).						If you or your dependents are covered by another plan, check box for each other plan. **DO NOT CHECK BOX IF THIS FUND IS THE ONLY COVERAGE.** If you checked the box for other coverage provide name, address and effective date of the other plan below.					
	Self	Sp	Ch	M	F	Date of Birth	Social Security Number	Medical	Dental	Drug	Vision

INFORMATION ABOUT OTHER INSURANCE COMPANIES

Name of participants with other coverage	Name, address of other plan	Effective date

INFORMATION ABOUT A SPOUSE OR CHILD NOT LIVING WITH YOU:

					Check box if this dependent has other coverage.			
Name	Sp	Ch	Date of Birth	Name, Address, SSN and Phone Number of Custodial Parent	Medical	Dental	Drug	Vision

AUTHORIZATIONS FOR DIRECT PAYMENT, CREDITS AND RELEASE OF INFORMATION (form will be returned if not signed or if any statements below which require response are not completed.

Payment authorization: I authorize payment to the provider for all benefits for services rendered to me and my eligible dependents by hospitals, physicians, dentists and other health care providers. ☐ **Yes** ☐ **No** **Payments for providers participating in Tri-State's medical and dental PPO networks are always paid directly to the providers.**

Health Care Credits and/or Benefit Experience Credits: **(Please see message on back of form if you are not the custodial parent of children covered by this plan.)** I request automatic reimbursement of any unpaid allowable expenses related to my health care claims and those of my eligible dependents from Health Care Credits or Benefit Experience Credits, if available under the Plan. ☐ **Yes** ☐ **No**

Exchange of health information: I understand that, in accordance with federal law, the Plan will communicate and exchange my health information and that of my dependents with other entities such as hospitals, health care providers, pharmacies, insurers and other benefit plans relating to treatment, payment and health care operations of the Plan.

False Information: I understand that knowingly filing a false or incomplete claim or concealing information relating to the claim, is a fraudulent act and may be a crime, may result in loss of coverage for me and my dependents and may require that we repay all amounts paid by the Plan and all costs of collection, including interest and attorney's fees.

Claim against another party: Do you have an injury or illness caused by someone else or for which someone else may be liable? ☐ **Yes** ☐ **No** (see back of form)

Member's signature: ______________________ **Date:** ____________

Spouse's signature: ______________________ **Date:** ____________

Dependent child over 18 Signature: ______________________ **Date:** ____________

***Custodial parent or legal guardian may sign where coverage is for minor dependent children of member**

Keep the yellow copy of this completed form for your records and return the signed white copy to:
I.B.T. Local 191 Health Services and Insurance Plan, 1139 Fairfield Avenue, Bridgeport, CT 06605

WHITE COPY – FUND OFFICE YELLOW COPY – MEMBER