TRI-STATE JOINT FUND RETIREE PLANS

ANNUAL INFORMATION REQUEST FORM - CALENDAR YEAR 20__

SEE BACK OF FORM FOR ADDITIONAL INFORMATION

Member Name _____TSJ# _____Local Number _____ Home Phone _____ Cell Phone _____
Primary Address _____ City _____ State _____ Zip _____ Dates normally at this address _____
Secondary Address _____ City _____ State _____ Zip _____ Dates normally at this address _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Widowed. If your marital status has changed, indicate the date of change _____

Any changes in the information on this form should be reported to the Retiree Department immediately.

PERSONAL INFORMATION - PLEASE PRINT CLEARLY

Name (First/Last) List all Participants covered under the Retiree Plan		Sex M/F	Date of Birth	Primary Street Address** Include Apt Number If a Participant DOES NOT live at the address above, write address below	City	State, Zip	Custodial Parent's Name (if applicable)	Is Participant Currently Employed?* Y/N	Current Employer's Name	Number of Hours Worked per Month	Does Current Employer Offer Health Insurance Y/N
	Self		/ /								
	SP		/ /								
	CH		/ /								
	CH		/ /								

* If employed, are you working for an employer contributing to the Fund or working in the same industry, trade, or craft, and geographic area covered by the Plan (CT, Western MA)? ☐ Yes ☐ No

You will be liable for any claims paid as primary in error for failure to inform the Plan about other insurances you have.

OTHER INSURANCE INFORMATION (NOT INCLUDING THIS RETIREE PLAN)

CHECK (√) what coverage each participant listed above has other than this Retiree Plan

Name (First/Last) If a Participant has any other insurance besides this Plan, include a copy of the insurance card(s) with this form		Name of Insurance Company Example: Medicare, Husky, Anthem, Cigna, etc.	Is this Insurance through an Employer? Y/N	Do You Pay for this Insurance? Y/N	Effective Date	Medical	Dental	Rx	Vision
	Self				/ /				
	SP				/ /				
	CH				/ /				
	CH				/ /				

AUTHORIZATIONS FOR DIRECT PAYMENT AND RELEASE OF INFORMATION (FORM WILL BE RETURNED IF NOT SIGNED OR IF ANY STATEMENTS BELOW WHICH REQUIRE RESPONSES ARE NOT COMPLETED.)

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. ☐ **YES** ☐ **NO**

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 the Plan's medical and dental PPO networks are always paid directly to the provider.)

Claim against another Party: Does anyone covered under this Plan have an injury or illness caused by someone else or for which someone else may be liable (including workers' compensation). ☐ **YES** ☐ **NO** (See back of form)

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 fees. ☐ **YES** ☐ **NO**

MEMBER'S SIGNATURE*_____DATE:_____

SPOUSE'S SIGNATURE _____DATE:_____

18+ YEAR OLD DEPENDENT SIGNATURE_____DATE:_____

18+ YEAR OLD DEPENDENT SIGNATURE_____DATE:_____

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

Please mail the completed form to Tri-State Joint Fund, Retiree Department, 609 West Johnson Avenue 2nd Floor, Cheshire, CT 06410