GENERAL TEAMSTERS LOCAL 493 HEALTH SERVICES AND INSURANCE PLAN ANNUAL INFORMATION REQUEST FORM - CALENDAR YEAR 20__

SEE BACK OF FORM FOR ADDITIONAL INFORMATION

Member Name _____TSJ# or Social Security #_____ Phone # _____ Cell Phone # _____Employer Name _____
Address_____ APT #_____City_____State_____Zip_____ **Marital Status:** ☐ Married ☐Single ☐Divorced ☐ Separated ☐Widow Date of change _____

☐**Check here if new address**

Any changes in the information on this form should be reported to Local 493 Fund Office immediately.

PERSONAL INFORMATION - PLEASE PRINT CLEARLY

Name (First/Last) List all Participants covered under this Plan		Sex M/F	Date of Birth	Social Security #	Marital Status	Street Address If a Participant DOES NOT live at the address above, write address below	City	State, Zip	Phone Number/ Custodial Parent's Phone Number (if applicable)	Custodial Parent's Name (if applicable)	Employed? Y/N	Employer Name
	Self		/ /									
	SP		/ /									
	CH		/ /									
	CH		/ /									
	CH		/ /									
	CH		/ /									
	CH		/ /									
	CH		/ /									

OTHER INSURANCE INFORMATION (NOT INCLUDING LOCAL 493 HSIP)

CHECK (√) what coverage each Participant has other than Local 493 HSIP

Name (First/Last) If a Participant has any other insurance besides Local 493 HSIP, include a copy of your insurance card with this form		Name of Insurance Company Example: Medicare, Husky, Anthem, Cigna, etc…	Is this Insurance through an Employer? Y/N	Does the Participant Pay for this Insurance? Y/N	Effective Date	Medical	Dental	Rx	Vision
	Self				/ /				
	SP				/ /				
	CH				/ /				
	CH				/ /				
	CH				/ /				
	CH				/ /				
	CH				/ /				
	CH				/ /				

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.)

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: Do you 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)

Local Specific Credits (if applicable): I request automatic reimbursement of any unpaid allowable expenses related to my health care claims and those of my eligible dependents from Local Specific Credits, if available under the Plan. ☐**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.

MEMBER'S SIGNATURE*_____DATE:_____
18+ YEAR OLD DEPENDENT SIGNATURE_____DATE:_____
18+ YEAR OLD DEPENDENT 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 return the signed form to General Teamsters Local 493 HSIP, PO Box 485, Uncasville, CT 06382

IMPORTANT INFORMATION ABOUT THE PLAN

YOU MAY BE REQUIRED TO SUBMIT ADDITIONAL INFORMATION SUCH AS A MARRIAGE CERTIFICATE, DIVORCE DECREE, LEGAL OR LONG FORM BIRTH CERTIFICATE, SOCIAL SECURITY CARD, OR ACKNOWLEDGEMENT OF PATERNITY.

THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE FUND OFFICE ONCE EACH CALENDAR YEAR BEFORE HEALTH CARE CLAIMS WILL BE PROCESSED FOR THE MEMBER OR ANY DEPENDENT.
Each year you are required to submit an Annual Information Request form (AIR). The form will be sent to you in the Fall of the prior year. It may also be obtained at the Fund Office or you may obtain it on the Tri-State website (www.trifund.com). The AIR form is used to update information about you and your eligible spouse and children. You, your spouse, and your dependent children over 18 must sign the form, acknowledge the assignment of benefits to certain providers, and authorize payment of Local Specific Credits. The custodial parent or legal guardian of a minor dependent may sign the AIR form on behalf of a dependent child not residing with the Employee. **NO CLAIM CAN BE PAID FOR A CALENDAR YEAR UNTIL A COMPLETED AND SIGNED AIR FORM IS RECEIVED BY THE LOCAL FUND OFFICE.**

ANY FUTURE CHANGES IN THE INFORMATION ON THIS FORM MUST BE REPORTED TO THE FUND IMMEDIATELY. FAILURE TO NOTIFY THE PLAN MAY RESULT IN:
Delay or denial of your claims, loss of eligibility in the Plan, loss of COBRA rights as described in section IV of your SPD, a demand for reimbursement of benefits paid in error, and/or the offset of all benefits for you and your dependents until the Plan is reimbursed in full.

LOCAL SPECIFIC CREDITS FOR CUSTODIAL PARENT OF DEPENDENT CHILD
Payments for automatic reimbursement of expenses from your Credits for your dependent children will always be made to the custodial parent of those children. For example, if you are divorced and your dependent children live with your ex-spouse, any payment of Credits for expenses incurred by your children will go directly to your ex-spouse. If you want to be reimbursed from your Credits for the expenses of the children who don't live with you, you must supply proof that YOU have made payment for expenses of the child.

CONTESTED WORKERS' COMPENSATION CLAIMS
The Fund is not liable for claims covered by Workers' Compensation. In the event you have a contested Workers' Compensation claim, if benefits are provided by this Fund, you are required to keep the Fund informed of its status. You are expected to reimburse the Fund for any payments made with respect to the claim from any settlement award you may receive.

WHEN THIRD PARTIES MAY BE LIABLE
If benefits are provided by this Fund, and if you or anyone acting on your behalf has a claim against any other party who may be responsible or liable for the cost of benefits paid by the Fund (including No-Fault, under-insured, or uninsured motorist insurance policies, or homeowners insurance policies), the Fund shall have first priority and lien on, and must be repaid out of any proceeds from such claim (however described or allocated). The amount to be repaid to the Fund shall be determined without any deduction or adjustment for costs and expenses related to the claim against the third party, including attorney's fees.

Before claims will be paid on your behalf, every person who is or may be entitled to receive compensation from a third party must execute a reimbursement agreement and other forms satisfactory to the Fund as a condition of receipt of benefits. The agreement must also be signed by your attorney or any successor attorney and is binding on them. **ONCE THE CLAIM IS SETTLED, THE FUND WILL NOT PAY FUTURE BENEFITS FOR CLAIMS DIRECTLY OR INDIRECTLY RELATED TO THAT INJURY.**

COVERAGE OF CHILDREN TO AGE 26
Children are eligible for coverage up to the last day of the month in which they turn 26. The child must be your biological child, stepchild, adopted child, or a child placed with you prior to formal adoption. You must be listed as a parent on your natural child's birth certificate, or an acknowledgment of paternity must be provided. Your stepchild must be the child of your spouse. You must provide proof of adoption or placement of your adopted child. Your child 18 or older will have to sign this AIR form in addition to the Employee and spouse, if applicable.

YOU MUST NOTIFY THE FUND OFFICE WHEN YOU OR YOUR DEPENDENTS BECOME ELIGIBLE FOR ANY OTHER HEALTH COVERAGE. FAILURE TO DO SO MAY MAKE YOU AND YOUR DEPENDENTS FINANCIALLY RESPONSIBLE FOR ANY CLAIMS PAID ON YOUR BEHALF.