

# ARIZONA SHEET METAL TRUST FUNDS

HEALTH AND WELFARE

ADMINISTRATIVE OFFICE

PENSION

2400 W. Dunlap Ave., Suite 250  
Phoenix, AZ 85021  
(602) 249-3582  
www.southwestservicepa.com

## Arizona Sheet Metal Trust Funds

Dear Participant:

In March of this year, you were sent a letter describing Medicare's new regulations that requires all health plans to report the social security numbers of ALL eligible family members to Medicare. Significant penalties apply to health plans that do not comply with Medicare's social security number requirements.

As of today, our records show that you have not provided the social security numbers of your dependents.

Another enrollment form is enclosed. Please complete it and return it promptly in the enclosed return envelope. Unless we receive your completed form by November 15<sup>th</sup>, **eligibility for you and your dependents may not be available beginning January 1, 2010 until the information is received.**

PLEASE NOTE: For any employee or family member that is eligible for Medicare, we MUST HAVE THE MEDICARE ID number also or simply send us a copy of the Medicare ID card, if you prefer.

We understand that some of you may be wary about giving out your family's social security numbers and we understand your concerns. Southwest Service Administrators follows all government standards when it comes to protecting your private information and, for your information, the social security number data sent to Medicare will be done so in a government approved, secured and encrypted format.

To read more on Medicare's requirements, go to [www.cms.hhs.gov/MandatoryInsRep](http://www.cms.hhs.gov/MandatoryInsRep).

Thank you for your cooperation.

Sincerely,

BOARD OF TRUSTEES  
October 2009

# ARIZONA SHEET METAL TRADE TRUST FUND

2400 WEST DUNLAP, SUITE 250  
PHOENIX, AZ 85021

TELEPHONE (602) 249-3582

TOLL FREE (800) 474-3485

FAX (602) 249-3795

## ENROLLMENT FORM

THIS FORM MUST BE COMPLETED FULLY UPON **ENTRY** INTO THE PLAN, **AND** IT MAY ALSO BE USED TO SUBMIT ANY UPDATED INFORMATION THROUGHOUT THE YEAR.

**✓ ENTRY VERIFICATIONS - IMPORTANT - DO NOT DELAY.** BEFORE BENEFITS FOR YOU AND YOUR FAMILY CAN BE PAID, YOUR FORM MUST BE SENT TO THE FUND OFFICE – **FULLY COMPLETED, SIGNED AND DATED BY YOU.** WITHOUT THIS INFORMATION THE FUND OFFICE **CANNOT CERTIFY BENEFITS** TO DOCTORS, HOSPITALS, LABS, PHARMACIES OR ANY OTHER HEALTH CARE PROVIDER. DO NOT WAIT UNTIL A FAMILY MEMBER NEEDS HEALTH CARE. SEND YOUR COMPLETED FORM AND REQUIRED ATTACHMENTS TO THE FUND OFFICE **NOW.**

**✓ TO UPDATE INFORMATION -** COMPLETE THE EMPLOYEE INFORMATION SECTION AND ANY SECTIONS THAT SHOW THE CHANGE YOU ARE REPORTING AND SEND TO THE FUND OFFICE.

**✓ CHECK ONE:**    **NEW EMPLOYEE**    **ADD SPOUSE**    **ADD NEWBORN/CHILD**    **CHANGE PERSONAL DATA**

### EMPLOYEE INFORMATION

<u>LAST NAME:</u>	<u>FIRST NAME:</u>	<u>MI:</u>	<input type="checkbox"/> M <input type="checkbox"/> F	<u>BIRTH DATE</u> / /
<u>ADDRESS</u>			<u>CITY</u>	<u>STATE</u>
			<u>ZIP</u>	<u>PHONE NO.</u> ( ) -
<u>SOCIAL SECURITY NO.</u>	<u>MARITAL STATUS</u>			<u>LOCAL UNION NO.</u>
<b>IF MEDICARE ELIGIBLE ATTACH A COPY OF YOUR MEDICARE CARD</b>	<input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED			

### SPOUSE INFORMATION

<u>LAST NAME:</u>	<u>FIRST NAME:</u>	<u>MI:</u>	<u>BIRTH DATE:</u> / /	<u>SOCIAL SECURITY NO.</u>
<u>IS YOUR SPOUSE EMPLOYED?</u> <input type="checkbox"/> NO <input type="checkbox"/> YES	<u>IF YES – EMPLOYER:</u>	<u>ADDRESS:</u>		<u>TELEPHONE NO.</u>

### SPOUSE OTHER INSURANCE INFORMATION

IS YOUR SPOUSE ENROLLED IN ANY OTHER EMPLOYER HEALTH PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO   MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO <small style="text-align: right;">IF MEDICARE ELIGIBLE ATTACH A COPY OF MEDICARE CARD</small>			
IF YES PLEASE INDICATE TYPE OF COVERAGE: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION			
<u>NAME OF INSURANCE</u> _____ <u>GROUP, I.D. OR HICN NUMBER:</u> _____			
<u>ADDRESS:</u> _____ <u>PHONE NUMBER ( )</u> _____			
<u>EFFECTIVE DATE OF COVERAGE:</u> ____/____/____			

*ELIGIBILITY FOR ALL PERSONS LISTED SHALL BE SUBJECT TO ALL PROVISIONS AND LIMITATIONS OF THE TRUST AGREEMENT AND PLAN DOCUMENT AS WELL AS TO ANY RULES OR REGULATION ADOPTED BY THE BOARD OF TRUSTEES. PLEASE SEE YOUR SUMMARY PLAN DESCRIPTION FOR A FULL EXPLANATION.*

(Continued on Reverse Side)

**DEPENDENT CHILDREN INFORMATION**

IF ADDITIONAL SPACE NEEDED ATTACH A SEPARATE SHEET

FULL NAME (LAST, FIRST, MI)	SEX	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP TO EMPLOYEE
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/ /	<input type="checkbox"/> NATURAL/ADOPTED CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER (SPECIFY)
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/ /	<input type="checkbox"/> NATURAL/ADOPTED CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER (SPECIFY)
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/ /	<input type="checkbox"/> NATURAL/ADOPTED CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER (SPECIFY)
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/ /	<input type="checkbox"/> NATURAL/ADOPTED CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER (SPECIFY)
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/ /	<input type="checkbox"/> NATURAL/ADOPTED CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER (SPECIFY)

**NOTE:** YOU MUST ATTACH A CERTIFIED COPY OF THE BIRTH CERTIFICATE FOR NEWLY ADDED DEPENDENTS. YOU MUST ATTACH A FULL TIME STUDENT CERTIFICATION FOR ANY DEPENDENT CHILD AGE 19 TO 23 ATTENDING SCHOOL.

**DEPENDENT CHILDREN - OTHER INSURANCE INFORMATION**

ARE ANY DEPENDENTS COVERED BY OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF YES, PLEASE INDICATE TYPE OF COVERAGE: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION		
IF YES – NAME OF COVERED EMPLOYEE:	SOCIAL SECURITY NO.	EFFECTIVE DATE OF COVERAGE
NAME OF OTHER PLAN:	ADDRESS	GROUP OR I.D. NUMBER

**NOTICE OF CHANGE:**  ADD DEPENDENT(S)  DELETE DEPENDENT(S)

<input type="checkbox"/> MARRIAGE	LAST NAME:	FIRST NAME:	SOCIAL SECURITY NO.	DATE OF BIRTH
<input type="checkbox"/> DIVORCE	IF OTHER – PLEASE EXPLAIN:			
<input type="checkbox"/> OTHER				
<input type="checkbox"/> MARRIAGE	LAST NAME:	FIRST NAME:	SOCIAL SECURITY NO.	DATE OF BIRTH
<input type="checkbox"/> DIVORCE	IF OTHER – PLEASE EXPLAIN:			
<input type="checkbox"/> OTHER				

**NOTE:** IF APPLICABLE YOU MUST ATTACH A COPY OF THE MARRIAGE CERTIFICATE OR DIVORCE DECREE OR COPY OF MEDICARE CARD

**FRAUD NOTICE**

I UNDERSTAND THAT THE TRUST FUND IS RELYING ON MY ANSWERS ON THIS FORM. I REPRESENT, UNDER PENALTY OF PERJURY, THAT THE ANSWERS GIVEN TO ALL QUESTIONS ON THIS FORM ARE TRUE AND ACCURATE. I UNDERSTAND THAT IF I KNOWINGLY AND WITH INTENT TO DEFRAUD THE TRUST FUND, PROVIDE FALSE INFORMATION OR CONCEAL, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, I MAY BE SUBJECT TO CIVIL AND CRIMINAL PENALTIES. I UNDERSTAND THAT IT IS A FEDERAL CRIME, PUNISHABLE BY FINE OR IMPRISONMENT, OR BOTH, TO KNOWINGLY MAKE FALSE STATEMENTS ON THIS VERIFICATION FORM.

**AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION TO PAY BENEFITS TO PROVIDER**

I HEREBY AUTHORIZE ANY PHYSICIAN OR HOSPITAL TO FURNISH AND DISCLOSE ALL KNOWN FACTS CONCERNING MY CLAIM. I WILL REIMBURSE THE FUND FOR ANY OVERPAYMENT MADE TO ME OR IN MY BEHALF DUE TO ERROR ON THIS FORM. I HERBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER FOR HIS SERVICES AS DESCRIBED HEREON OR IN SUPPLEMENTAL STATEMENTS, NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGES FOR THOSE SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN FORCE UNTIL CANCELLED IN WRITING BY ME.

**BENEFICIARY INFORMATION**

PLEASE UPDATE YOUR BENEFICIARY INFORMATION.

IF ADDITIONAL SPACE NEEDED ATTACH SEPARATE SHEET

FULL NAME AND ADDRESS (PLEASE PRINT)	RELATIONSHIP	% OF LIFE AND/OR LIFE AND AD&D INSURANCE PROVIDED BY H&W PLAN	% OF PENSION BENEFIT, IF APPLICABLE
NAME: ADDRESS:			
NAME: ADDRESS:			

EMPLOYEE SIGNATURE

SOCIAL SECURITY NUMBER

DATE