

**SMWIA LOCAL 49 FAMILY HEALTH PLAN**  
**2400 West Dunlap Avenue, Suite 250**  
**Phoenix, Arizona 85021**  
**Phone (505) 265-8422 Toll Free (800) 432-6636 Fax (505) 266-9358**

**EMPLOYEE & DEPENDENT ELIGIBILITY INFORMATION VERIFICATION FORM**

This form must be completed fully upon **ENTRY** into the plan, **AND** at the beginning of each year. 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 TO THE FUND OFFICE NOW.**

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

| EMPLOYEE INFORMATION  |             |            |  |                      |                               |
|---|-------------|------------|--|----------------------|-------------------------------|
| 1. LAST NAME:   | FIRST NAME: | MI:        | <input type="checkbox"/> M<br><input type="checkbox"/> F | 2. BIRTH DATE<br>/ / | 3. SOCIAL SECURITY NO.<br>- - |
| 4. ADDRESS <input type="checkbox"/> CHECK HERE IF NEW ADDRESS |             |            |  | CITY                 | STATE ZIP                     |
| 6. EMPLOYER   |             | 7. ADDRESS |  | CITY STATE ZIP       | 8. PHONE NUMBER<br>( ) -      |

| SPOUSE INFORMATION   |             |             |  |                       |                                |
|--|-------------|-------------|--|-----------------------|--------------------------------|
| 9. LAST NAME:  | FIRST NAME: | MI:         |  | 10. BIRTH DATE<br>/ / | 11. SOCIAL SECURITY NO.<br>- - |
| 12. IS YOUR SPOUSE EMPLOYED?<br><input type="checkbox"/> NO <input type="checkbox"/> YES |             | 13. ADDRESS |  | CITY STATE ZIP        | 14. PHONE NUMBER<br>( ) -      |

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 REGULATIONS ADOPTED BY THE BOARD OF TRUSTEES. PLEASE SEE YOUR SUMMARY PLAN DESCRIPTION FOR A FULL EXPLANATION.

| SPOUSE COORDINATION OF BENEFITS INFORMATION   |  |         |  |                   |  |
|---|--|---------|--|-------------------|--|
| 15. DOES YOUR SPOUSE'S EMPLOYER OFFER A GROUP MEDICAL PLAN INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |         |  |                   |  |
| 16. IS YOUR SPOUSE ENROLLED IN HIS/HER EMPLOYER PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |         |  |                   |  |
| IF YES - PROVIDE NAME OF OTHER PLAN   |  | ADDRESS |  | GROUP OR I.D. NO. |  |
| PLEASE INDICATE TYPE OF COVERAGE: <input type="checkbox"/> MEDICAL, <input type="checkbox"/> DENTAL, <input type="checkbox"/> VISION, <input type="checkbox"/> PRESCRIPTION DRUGS |  |         |  |                   |  |
| 17. MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF MEDICARE ELIGIBLE ATTACH A COPY OF THE MEDICARE CARD) HICN HNUMBER _____                               |  |         |  |                   |  |

**18. 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 MATERIALLY 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.

**19. 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.

EMPLOYEE'S SIGNATURE

SOCIAL SECURITY NUMBER

DATE

--OVER--

**20. DEPENDENT CHILDREN INFORMATION**

**NOTE: YOU MUST ATTACH A BIRTH CERTIFICATE FOR NEWLY ADDED DEPENDENTS. YOU MUST ATTACH AN ADULT DEPENDENT CERTIFICATION FORM FOR ANY DEPENDENT CHILD AGE 19 TO 26.**

|  |                   |               |  |  |
|--|-------------------|---------------|--|--|
| FULL NAME (LAST, FIRST, MIDDLE INITIAL)      | SOCIAL SECURITY # | DATE OF BIRTH | SEX  | RELATIONSHIP TO EMPLOYEE   |
|  | / /               | / /           | <input type="checkbox"/> M<br><input type="checkbox"/> F | <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD<br><input type="checkbox"/> OTHER, SPECIFY: |
| ADDRESS: <input type="checkbox"/> SAME   OR: |                   |               |  |  |
|  | / /               | / /           | <input type="checkbox"/> M<br><input type="checkbox"/> F | <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD<br><input type="checkbox"/> OTHER, SPECIFY: |
| ADDRESS: <input type="checkbox"/> SAME   OR: |                   |               |  |  |
|  | / /               | / /           | <input type="checkbox"/> M<br><input type="checkbox"/> F | <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD<br><input type="checkbox"/> OTHER, SPECIFY: |
| ADDRESS: <input type="checkbox"/> SAME   OR: |                   |               |  |  |
|  | / /               | / /           | <input type="checkbox"/> M<br><input type="checkbox"/> F | <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD<br><input type="checkbox"/> OTHER, SPECIFY: |
| ADDRESS: <input type="checkbox"/> SAME   OR: |                   |               |  |  |
|  | / /               | / /           | <input type="checkbox"/> M<br><input type="checkbox"/> F | <input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD<br><input type="checkbox"/> OTHER, SPECIFY: |
| ADDRESS: <input type="checkbox"/> SAME   OR: |                   |               |  |  |

**21. DEPENDENT COORDINATION OF BENEFITS INFORMATION**

|   |   |                               |
|---|---|-------------------------------|
| IS DEPENDENT COVERED BY ANOTHER PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF MEDICARE ELIGIBLE ATTACH A COPY OF MEDICARE CARD | IF YES - SHOW NAME OF COVERED EMPLOYEE: | SOCIAL SECURITY NUMBER<br>/ / |
| IF YES, PLEASE INDICATE TYPE OF COVERAGE:<br><input type="checkbox"/> MEDICAL <input type="checkbox"/> VISION <input type="checkbox"/> RX   | EFFECTIVE DATE OF COVERAGE:             | GROUP OR I.D NUMBER:          |
| NAME OF OTHER PLAN:   | ADDRESS:                                |                               |

**22. NOTICE OF CHANGE:   ADD DEPENDENT(S)      DELETE DEPENDENT(S)**   
**IF ADDING OR DELETING A DEPENDENT SPOUSE - MARRIAGE CERTIFICATE OR DIVORCE DECREE MUST BE ATTACHED**

|   |            |             |                          |            |
|---|------------|-------------|--------------------------|------------|
| MARRIAGE <input type="checkbox"/><br>DIVORCE <input type="checkbox"/><br>OTHER <input type="checkbox"/> | LAST NAME: | FIRST NAME: | SOCIAL SECURITY #<br>/ / | DOB<br>/ / |
| IF OTHER - PLEASE EXPLAIN:  |            |             |                          |            |
| MARRIAGE <input type="checkbox"/><br>DIVORCE <input type="checkbox"/><br>OTHER <input type="checkbox"/> | LAST NAME: | FIRST NAME: | SOCIAL SECURITY #<br>/ / | DOB<br>/ / |
| IF OTHER - PLEASE EXPLAIN:  |            |             |                          |            |

**23. BENEFICIARY DESIGNATIONS   \*\*\*\*FAMILY HEALTH PLAN ONLY\*\*\*\*   BENEFICIARY DESIGNATIONS**

|   |               |   |               |
|---|---------------|---|---------------|
| <b>LIFE INSURANCE (LOCAL 49 MEMBERS ONLY)</b>   |               | <b>VACATION BENEFITS (LOCAL 49 MEMBERS ONLY)</b>  |               |
| <input type="checkbox"/> CHECK HERE IF YOUR SPOUSE IS YOUR BENEFICIARY. DO NOT COMPLETE INFORMATION BELOW |               | <input type="checkbox"/> CHECK HERE IF YOUR SPOUSE IS YOUR BENEFICIARY. DO NOT COMPLETE INFORMATION BELOW |               |
| NAME  | DATE OF BIRTH | NAME  | DATE OF BIRTH |
| RELATIONSHIP  | SS#           | RELATIONSHIP  | SS#           |
| ADDRESS   |               | ADDRESS   |               |
| CITY  | STATE   ZIP   | CITY  | STATE   ZIP   |
| <b>NAT'L PENSION FUND (LOCAL 49 MEMBERS ONLY)</b>   |               | <b>SASMI BENEFITS (LOCAL 49 MEMBERS ONLY)</b>   |               |
| <input type="checkbox"/> CHECK HERE IF YOUR SPOUSE IS YOUR BENEFICIARY. DO NOT COMPLETE INFORMATION BELOW |               | <input type="checkbox"/> CHECK HERE IF YOUR SPOUSE IS YOUR BENEFICIARY. DO NOT COMPLETE INFORMATION BELOW |               |
| NAME  | DATE OF BIRTH | NAME  | DATE OF BIRTH |
| RELATIONSHIP  | SS#           | RELATIONSHIP  | SS#           |
| ADDRESS   |               | ADDRESS   |               |
| CITY  | STATE   ZIP   | CITY  | STATE   ZIP   |
| <input type="checkbox"/> PLEASE CHECK HERE IF YOU WOULD LIKE TO RECEIVE NEW MEDICAL ID CARDS              |               |   |               |