SMWIA LOCAL 49 FAMILY HEALTH PLAN
4775 Indian School Road, N.E., Suite 105
Albuquerque, New Mexico 87110
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 or yearly 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**. 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.***

✓ ***To update information*** - Complete the Employee Information section and sections that show the change you are reporting, and send to the Fund office.

CHECK ONE: ☐ NEW EMPLOYEE ☐ YEARLY UPDATE ☐ CHANGE OF STATUS VERIFICATION

EMPLOYEE INFORMATION

1. LAST NAME:	FIRST NAME:	MI:	☐ M ☐ F	2. BIRTH DATE / /	3. SOCIAL SECURITY NO. _ _
4. ADDRESS ☐ CHECK HERE IF NEW ADDRESS CITY STATE ZIP					5. PHONE NUMBER ( ) -
6. EMPLOYER	7. ADDRESS CITY STATE ZIP				8. PHONE NUMBER ( ) -

SPOUSE INFORMATION

9. LAST NAME:	FIRST NAME:	MI:	10. BIRTH DATE / /	11. SOCIAL SECURITY NO. _ _
12. IS YOUR SPOUSE EMPLOYED? ☐ NO ☐ YES	IF YES - EMPLOYER:	13. ADDRESS CITY STATE ZIP		14. PHONE NUMBER ( ) -

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? ☐ YES ☐ NO

16. IS YOUR SPOUSE ENROLLED IN HIS/HER EMPLOYER PLAN? ☐ YES ☐ NO

IF YES - PROVIDE NAME OF OTHER PLAN ADDRESS GROUP OR I.D. NO.

_____

PLEASE INDICATE TYPE OF COVERAGE: ☐ MEDICAL, ☐ DENTAL, ☐ VISION, ☐ PRESCRIPTION DRUGS

17. MEDICARE? ☐ YES ☐ NO (IF MEDICARE ELIGIBLE ATTACH A COPY OF THE MEDICARE CARD) HICN HUMBER _____

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--