

Phoenix Painting Industry Trust Funds

HEALTH AND WELFARE

ADMINISTRATIVE OFFICE

PENSION

Southwest Service Administrators, Inc.
2400 W. Dunlap Ave., Suite 250
Phoenix, Arizona 85021

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Phoenix Painting Industry 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 15th, **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.

Thank you for your cooperation.

Sincerely,

BOARD OF TRUSTEES
October 2009

Trustmark

GROUP INSURANCE

Trustmark Life Insurance Company

Annual Enrollment Form

Group Name PHOENIX PAINTING INDUSTRY TRUST FUND	Group # JE882	Date of Hire:	
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Enrollment for Health, Life, AD&D, Dental and Vision coverage.
 New Enrollment Add Newborn Annual Enrollment Add Spouse Change Personal Data

Employee Name (Last, First, MI)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number	Phone Number
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Employee Address (Street Address, City, State, Zip Code)

Marital Status: Single Married* Divorce* Widowed* Legally Separated
 Date of Marriage: _____
**Please include supporting documentation*

OTHER INSURANCE INFORMATION

Are you, your spouse or any of your dependents covered by any other medical insurance plan? Yes No
 Medicare? Yes No

If yes, attach a copy of your Medicare Card

Please indicate the type of other coverage indicated above:

Medical Dental Vision Prescription Drug Plan

Name of Insured Covered by Other Medical Insurance Plan	Name and Address of Other Medical Insurance	Group or I.D. Number	Effective Date of Coverage

COMPLETE ONLY IF COVERAGE INCLUDES DEPENDENT COVERAGE:

(attach an additional page if necessary)

Dependent's Full Name	Relationship	Sex	Social Security Number	Birth Date	Full Time Student	Other Medical Insurance
	<input type="checkbox"/> Spouse	<input type="checkbox"/> M <input type="checkbox"/> F			N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Stepchild* <input type="checkbox"/> Other* _____	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Stepchild* <input type="checkbox"/> Other* _____	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Natural/Adopted Child <input type="checkbox"/> Stepchild* <input type="checkbox"/> Other* _____	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Please complete and attach the appropriate spousal/dependent verification form*

Beneficiary Designation:
(attach an additional page if necessary)

Primary: _____ Relationship: _____ %: _____
 Contingent: _____ Relationship: _____ %: _____

The information on this form shall replace any previously dated forms that may be on file.

THIS FORM WILL NOT BE ACCEPTED BY TRUSTMARK LIFE INSURANCE COMPANY UNLESS SIGNED AND DATED BY THE INSURED/EMPLOYEE.

Employee's Signature



Date

Trustmark GROUP INSURANCE

FRAUD WARNING

Any person who knowingly completes this application with false, misleading or incomplete information may be subject to civil and criminal penalties.

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE THE ENTITIES LISTED IN THIS AUTHORIZATION TO GIVE TRUSTMARK, AND THROUGH IT, TO ITS REINSURERS AND THE MEDICAL INFORMATION BUREAU ANY FINANCIAL OR MEDICAL [MQ1] DATA OR RECORDS IN THE ENTITIES POSSESSION ABOUT ME OR MY MENTAL OR PHYSICAL HEALTH. THIS AUTHORIZATION APPLIES TO FINANCIAL OR MEDICAL DATA OR RECORDS ABOUT MY SPOUSE AND ANY CHILD PROPOSED FOR INSURANCE IN THIS APPLICATION. THIS AUTHORIZATION IS FOR: ANY MEDICAL PRACTITIONER; HOSPITAL; CLINIC OR OTHER MEDICALLY RELATED FACILITY; INSURANCE COMPANY; OR THE MEDICAL INFORMATION BUREAU [MQ2] WHICH MAY HAVE FINANCIAL OR MEDICAL INFORMATION PERTINENT TO DETERMINE MY ELIGIBILITY FOR INSURANCE. THIS AUTHORIZATION IS VALID FOR TWO YEARS FROM THE DATE OF THIS AUTHORIZATION. A PHOTOGRAPHIC OR FACSIMILE COPY OF THIS AUTHORIZATION WILL BE AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I CAN REVOKE THIS AUTHORIZATION AT ANY TIME BY GIVING WRITTEN NOTICE TO TRUSTMARK. I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION AND STILL BE ASSURED TREATMENT. (MY AUTHORIZED REPRESENTATIVE AND I ARE ENTITLED TO RECEIVE A COPY OF THIS AUTHORIZATION.)