

# SOUTHWESTERN TEAMSTERS SECURITY FUND

---

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

Phone (602) 249-3582  
Toll free (800) 474-3485  
Fax (602) 336-0895  
[www.southwestservicetpa.com](http://www.southwestservicetpa.com)

## Southwestern Teamsters Security Fund

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

# SOUTHWESTERN TEAMSTERS SECURITY 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. BENEFITS WILL NOT BE PAID FOR SERVICES RECEIVED UNTIL THIS FORM IS 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.**

**✓ 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 NUMBER</u>	<u>MARITAL STATUS</u> <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED			<u>LOCAL UNION NO.</u>		
<b>IF MEDICARE ELIGIBLE ATTACH A COPY OF YOUR MEDICARE CARD</b>						

### 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 NUMBER</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	
IF YES: <input type="checkbox"/> FOR SELF ONLY <input type="checkbox"/> FOR SELF AND DEPENDENTS		IF MEDICARE ELIGIBLE ATTACH A COPY OF MEDICARE CARD	
PLEASE INDICATE TYPE OF COVERAGE: <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION			
NAME OF INSURANCE _____		GROUP, I.D. OR HICN NUMBER: _____	
ADDRESS _____		TELEPHONE NUMBER (____) _____	
EFFECTIVE DATE OF COVERAGE    ____ / ____ / ____			
<i>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.</i>			

(Continued on Reverse Side)

**DEPENDENT CHILDREN INFORMATION**

IF ADDITIONAL SPACE IS NEED ATTACH A SEPARATE SHEET

FULL NAME (LAST, FIRST, MI)	SEX	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIP TO EMPLOYEE
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/ /	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER SPECIFY
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/ /	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER SPECIFY
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/ /	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER SPECIFY
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/ /	<input type="checkbox"/> NATURAL CHILD <input type="checkbox"/> STEP CHILD <input type="checkbox"/> OTHER SPECIFY
	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/ /	<input type="checkbox"/> NATURAL 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 OTHER INSURANCE INFORMATION**

ARE ANY DEPENDENTS COVERED BY OTHER INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No		MEDICARE? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Medicare eligible attach a copy of Medicare card			
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 NUMBER	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 <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER	LAST NAME:	FIRST NAME:	SOCIAL SECURITY	DATE OF BIRTH
	IF OTHER – PLEASE EXPLAIN:			
<input type="checkbox"/> MARRIAGE <input type="checkbox"/> DIVORCE <input type="checkbox"/> OTHER	LAST NAME:	FIRST NAME:	SOCIAL SECURITY	DATE OF BIRTH
	IF OTHER – PLEASE EXPLAIN:			

**NOTE:** If applicable you must attach a copy of the marriage certificate or divorce decree

**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****LIFE INSURANCE AND/OR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**

FULL NAME AND ADDRESS (PLEASE PRINT)	DATE OF BIRTH	RELATIONSHIP	% OF BENEFIT

**NOTE:** If additional space is needed attach a separate sheet

**EMPLOYEE SIGNATURE** \_\_\_\_\_

**SOCIAL SECURITY NUMBER** \_\_\_\_\_

**DATE** \_\_\_\_\_