Operating Engineers' Local No. 428 Health & Welfare Trust Fund

P.O. Box 43110, Phoenix, AZ 85080-3110
Toll Free: (800) 474-3485 Fax: (480) 302-2237
www.SSATPA.com

Enrollment Form

IMPORTANT - DO NOT DELAY. Before benefits for you and your family can be paid this 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.

ENROLLMENT, CHANGE OR LIFE EVENT NOTICES

REASON YOU ARE COMPLETING THIS FORM; CHECK ALL BOXES THAT APPLY. PRINT LEGIBLY USING BLACK INK TO IMPROVE PROCESSING OF YOUR FORM AND DATA. IF YOU DO NOT FILL OUT THIS FORM COMPLETELY AND ATTACH DOCUMENTATION, IT WILL BE RETURNED TO YOU AND YOUR COVERAGE WILL NOT BE UPDATED UNTIL ALL OF THE DATA IS SUBMITTED AND THE FORM IS SIGNED AND DATED.

✓ **CHECK ALL THAT APPLY:**

☐ NEW ENROLLMENT ☐ CHANGE PERSONAL DATA

☐ REMOVE SPOUSE ☐ REMOVE CHILD ☐ ADD SPOUSE ☐ ADD CHILD

1) EMPLOYEE INFORMATION

LAST NAME:	FIRST NAME:	MI:	GENDER:
			☐ M ☐ F

BIRTH DATE:	SOCIAL SECURITY NO. *	PHONE NO.
/ /	/ /	( ) -

ADDRESS	CITY	STATE	ZIP

MARITAL STATUS:	EMAIL ADDRESS:	LOCAL UNION NO.
☐ Married ☐ Divorced ☐ Single ☐ Widowed		

2) SPOUSE INFORMATION – DO NOT COMPLETE IF YOU ARE NOT CURRENTLY MARRIED.

If married and listing a spouse, you must attach a copy of your marriage certificate.

LAST NAME:	FIRST NAME:	MI:	GENDER:	SOCIAL SECURITY NO. *
			☐ M ☐ F	/ /

ADDRESS (IF DIFFERENT FROM EMPLOYEE):	BIRTH DATE:
	/ /

PHONE NO.	IS YOUR SPOUSE EMPLOYED?	IF YES – EMPLOYER:
( ) -	☐ NO ☐ YES	

MEDICARE ELIGIBLE? (IF MEDICARE ELIGIBLE ATTACH A COPY OF YOUR MEDICARE CARD)
☐ YES ☐ NO

- *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.*

* **Coverage will not begin until social security numbers have been provided**

3) DEPENDENT(S) – You must attach a copy of the certified birth certificate for newly added dependents

If additional space needed attach a separate sheet

FULL NAME (LAST,FIRST, MI)	SEX	DATE OF BIRTH	Social Security No. *	RELATIONSHIP TO EMPLOYEE
	□ M □ F	/ /	/ /	□ Natural/Adopted Child □ Step Child □ Other (Specify) _____
	□ M □ F	/ /	/ /	□ Natural/Adopted Child □ Step Child □ Other (Specify) _____
	□ M □ F	/ /	/ /	□ Natural/Adopted Child □ Step Child □ Other (Specify) _____
	□ M □ F	/ /	/ /	□ Natural/Adopted Child □ Step Child □ Other (Specify) _____
	□ M □ F	/ /	/ /	□ Natural/Adopted Child □ Step Child □ Other (Specify) _____

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.

4) BENEFICIARY INFORMATION – Please update your beneficiary information.

If additional space needed attach a separate sheet

FULL NAME (LAST,FIRST, MI)	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP
	/ /	/ /	

ADDRESS	CITY	STATE	ZIP

✓_____ _____

Employee Signature Date