Kalamazoo Plumbers, Steamfitters and Pipefitters
Local 357 Health and Welfare Insurance Plan
Participant Enrollment Application

Select Position: ☐ New Union Member ☐ Newly Organized ☐ Apprentice Initiation Date: ____________________

Select coverage type: ☐ Employee Only ☐ Employee plus One ☐ Employee plus Family

Name: Last	First	Middle	Are you: ☐ Single ☐ Married ☐ Sep. ☐ Div. ☐ Widowed	Home Phone number: ( )
Address: Street	**City**	**State**	**Zip**	**County**

Please complete for each eligible family member you want covered, including yourself. (Your spouse and any eligible dependents.) Important; Check "Yes" for other Group coverage **<u>only</u>** if it will remain in effect. Attach a second sheet, if necessary.

First Name Middle Last (if different)	Sex M/F	Relationship to Applicant *	Date of Birth Mo	Day	Yr	Social Security Number	Totally Disabled	Enrolled in Medicare	Enrolled in other Group Coverage
00 Applicant		**SELF**					☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
01 Spouse							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
02 Child							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
03 Child							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
04 Child							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
05 Child							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
06 Child							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Medicare Information: If you or any dependents checked "YES" please provide the following and attach copy of Medicare card:

Name	Medicare No.	Part A / Part B eff. Date	Reason for Medicare Eligibility

B. Opt-Out of Coverage

☐ I wish to opt out of coverage through the Kalamazoo Plumbers, Steamfitters and Pipefitters Local 357 Health and Welfare Insurance Plan (the "Plan"). I understand that by opting out of coverage: (1) I will have no health, prescription, dental, or vision coverage through the Plan; (2) unless I qualify for special enrollment, I will not be able to re-enroll in the Plan again until the next enrollment period (December of next year); (3) I will not receive any contribution funds back into my account; and (4) my employer's contribution into the Plan will continue to remain the same.

C. Certification

I certify that I have reviewed this form and any appended documents thoroughly. I certify that the information provided in this form is correct. I understand that: (1) my coverage is contingent upon me maintaining eligibility as defined under the Plan; (2) I must use the providers that participate in the Plan I have chosen; (3) I will be financially responsible for any and all expenses, including deductibles and co-pays; and (4) I will be financially liable for payment of claims based upon inaccurate or misleading information provided by me. I further understand that unless I qualify for special enrollment, my election *<u>cannot be changed</u>* until the next open enrollment period (December of next year).

______________________________ ______________________

Applicant Signature Date