ENROLLMENT/ CHANGE FORM

Steelworkers Health and Welfare Fund
60 Boulevard of the Allies, Fifth Floor, Pittsburgh, PA 15222
Phone: 1-888-296-7493 Fax: 412-201-1138
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PLEASE PRINT CLEARLY

EMPLOYER INFORMATION (To Be Completed By Employer)

Group No.	Group Name	Date of Hire Mo/Day/Yr / /	Coverage / Change Effective Date Mo/Day/Yr / /

ENROLL
- ❑ Open Enrollment
- ❑ New Hire
- ❑ Reinstatement
- ❑ Other _____

CHANGE
- ❑ Add Dependent (reason) _____
- ❑ Delete Dependent (reason) _____
- ❑ Address Change _____
- ❑ Transfer from Group _____ To Group _____
- ❑ Other _____

TERMINATE
- ❑ Termination of Employment
- ❑ Death of Employee
- ❑ Reduction of Hours
- ❑ Military Service
- ❑ Other _____

Check Type of Coverage	MEDICAL	DENTAL	VISION	LIFE/ADD	STD
Employee Only	❑	❑	❑	❑	❑
Employee + Child	❑	❑	❑	❑	
Employee + Children	❑	❑	❑	❑	
Employee + Spouse	❑	❑	❑	❑	
Family	❑	❑	❑	❑	

EMPLOYEE INFORMATION (To Be Completed By Employee)

Social Security #	Last Name	First Name	Middle Initial	Sex M / F	Birth Date Mo / Day / Year
					/ /

Home Address / Apt. No. **City** **State** **Zip Code**

Home Telephone ( ) **Work Telephone** ( )

COVERED FAMILY MEMBERS

First Name	Middle Initial	Last Name (if different than the Employee)	Social Security Number	Sex M	Sex F	Birth date Mo/Day/Yr	Dependent 19 or older* FTS	Dependent 19 or older* DD
Spouse				❑	❑	/ /		
Dependent				❑	❑	/ /	❑	❑
Dependent				❑	❑	/ /	❑	❑
Dependent				❑	❑	/ /	❑	❑
Dependent				❑	❑	/ /	❑	❑
Dependent				❑	❑	/ /	❑	❑

* Dependent Codes: FTS - Full Time Student (FTS code to be used for retiree only plans exclusively and a Dependent Questionnaire must be completed and attached)
DD - Disabled Dependent (if dependent is over age 26 for active plans or age 19 for retiree only plans, a Disabled Dependent Certification form must be completed and attached)

OTHER COVERAGE If you or any family members are covered by other group health insurance, including Medicare, please complete this section

Name of Member	Name of Other Group Health Insurance (including Medicare) & Policy Number	Effective Date
		/ /
		/ /

I certify that the information provided on this form is true to the best of my knowledge. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above for benefits as described in the agreement between my employer and the Steelworkers Health and Welfare Fund ("the Fund"). I authorize any payroll deductions required for the coverage and recognize that I must enroll my dependents on this form or they will not be covered. I understand that it is my responsibility to report to my employer any change in the eligibility of the individuals listed above or any change to the information I have provided in this Form. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, the Fund may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of the Fund's Notice of Privacy Practices is included in the Summary Plan Description (SPD) issued by the Fund or from the Fund's Privacy Official.

X	/ /	X	/ /
Employee Signature	**Date Signed Mo/Day/Yr**	**Employer Signature**	**Date Signed Mo/Day/Yr**