CBA Blue

IBEW Local 300
Enrollment/Change Form

☐ New Enrollment
☐ No Change
☐ Change

P.O. Box 2365
South Burlington, VT 05407-2365 FAX# (802) 862-7661

EMPLOYEE – MUST COMPLETE ALL INFORMATION IN SECTIONS 1 THROUGH 7

SECTION 1 – EMPLOYEE PARTICIPANT INFORMATION

Social Security Number	Last Name ☐ check if new	First Name	MI	Date of Birth

Home Mailing Address ☐ check if new	City	State	Zip Code

Gender ☐ Male ☐ Female	Home Phone	Work Phone	Current Marital Status ☐SINGLE ☐ MARRIED

SECTION 2 – DEPENDENT INFORMATION

	Check One	LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH MM/DD/YYYY	SOCIAL SECURITY #	Enter "Dep" Relationship Code
Spouse or Partner	☐Add ☐Delete				☐M ☐F			
Dep-1	☐Add ☐Delete				☐M ☐F			
Dep-2	☐Add ☐Delete				☐M ☐F			
Dep-3	☐Add ☐Delete				☐M ☐F			
Dep-4	☐Add ☐Delete				☐M ☐F			
Dep-5	☐Add ☐Delete				☐M ☐F			

DEP Relationship Codes:
C-Child (Birth/Adoption) **L**-Legal Guardianship* **CO**-Court Order Coverage* **SP**-Spouse **D**-Disabled Child (attach Physician Statement **DP**-Domestic Partner** **S**-Stepchild***
*= Attach Court Order **= Attach Statement of Domestic Partnership *** = Who is legally responsible for stepchild(s) medical bills? _____

SECTION 3 – ENROLLMENT CHOICES- Plan Selection

☐ Elect Medical Coverage: ☐ EE ☐ EE + Spouse ☐ Family ☐ EE + Child

☐ Elect Dental Coverage: ☐ EE ☐ EE + Spouse ☐ Family ☐ EE + Child

☐ Waive Coverage: Medical

☐ Waive Coverage: Dental

SECTION 4 - SPOUSE EMPLOYER INFORMATION

Is Spouse Employed? ☐Yes ☐ No If yes, provide Name & Address of Employer: _____

Does Spouse's Employer offer medical and/or dental coverage? Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No

SECTION 5 - OTHER COVERAGE

Do you, your spouse or dependent(s) maintain other health or dental coverage? ☐ YES ☐ NO If Yes, complete below and provide a copy of the Plan's ID card.

Policyholder Name	Policy Number	Group Number	Insurance Company Name & Address	Effective Date: ☐Single ☐ 2P ☐ Family
Policyholder Name	Policy Number	Group Number	Insurance Company Name & Address	Effective Date: ☐Single ☐ 2P ☐ Family

Are you, your spouse or any dependents listed in Section 2 enrolled in Medicare? ☐ Yes ☐ No
If yes, attach a copy of Medicare card(s). ☐Actively Working ☐ Retired ☐ Under Age 65 ☐ ESRD (End Stage Renal Disease)

SECTION 6: HIPAA COMPLIANCE

Will this plan replace existing health insurance coverage? ☐YES ☐NO If **yes, attach a certificate of prior health insurance coverage.** Your Prior insurer will give you this form.

SECTION 7: SUBSCRIBER SIGNATURE

I certify that the statements on this enrollment form and all information furnished by me are true and complete to the best of my knowledge. I and any enrolled dependants agree to permit any healthcare provider to release/disclose any information (including Protected Health Information) acquired in connection with any past or future care or treatment to CBA, Inc. dba CBA Blue, or its designated agent for purposes of administering coverage.

Subscriber's Signature **Date**

****EMPLOYER USE ONLY – EMPLOYER CHECK AND COMPLETE APPROPRIATE AREAS BELOW****

COVERAGE EFFECTIVE DATES:	Medical Effective Date:	Dental Effective Date:	
EMPLOYEE STATUS:	Date of Hire: / or Eligibility Date:	☐ New Hire ☐ Rehire ☐ Open Enrollment ☐ HIPAA Qualifying Event (describe event): _____	
	Plan Division/Subgroup: Division/Subgroup: ☐ Active Division #: ☐ Retiree Division # ☐ COBRA Division # You can locate your division number on CBAs structure document provided during the implementation.	Plan Type Medical: ☐ Medical Plan Plan Type Dental: ☐ Dental Plan	Employment Status: ☐ Full-Time ☐ Part-Time
REASON FOR STATUS CHANGE:	Effective Date:	☐ Marriage ☐ Name Change ☐ Address Change ☐ Open Enrollment ☐ Surviving Spouse ☐ Loss of Coverage (Certificate Creditable Coverage Required) ☐ Transfer ☐ HIPAA Qualifying Event (describe event): _____	
CANCEL COVERAGE:	Effective Date:	CANCEL: ☐ All ☐ Spouse ☐ Dependents (list in Section 2)	REASON: ☐ COBRA ☐ Divorce ☐ Retired ☐ Death ☐ Left Employment ☐ Dependent Over Age ☐ Other (describe below):

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

ENROLLMENT AND BENEFICIARY FORM

PLEASE PRINT

INSTRUCTIONS: This form is to be utilized for enrollment and beneficiary purposes only. All correspondence and questions should be addressed to the Fund/Employer maintaining your eligibility information.

- **For all new additions and reinstatements, complete the entire form, and sign at the bottom.**
- **For all other needs, complete the appropriate section, and sign at the bottom.**

Please check: ☒ **New enrollment** ☐ **Reinstatement** ☐ **Address Change** ☐ **Beneficiary Change**

SECTION A – Policyholder Information

Name of group policyholder: IBEW Local 300 Health and Welfare Fund Policy number: # G-3312

Effective date: _____ Local/Bill ID: _____

SECTION B – Insurance Amount

Life amount: $50,000.00 AD&D amount: $50,000.00 AH amount: $_____ LTD amount: $_____

Billing classes: _____ _____ _____ _____

☐ Duplicate certificate request

SECTION C – Insured Information

☐ Male ☐ Female
☐ Active ☐ Retiree

Name of insured: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Date of birth: _____

Occupation: _____ Weekly earnings: _____ Date started working: _____

SECTION D – Beneficiary

NOTE: If the beneficiary is being changed, the new beneficiary will replace all prior designations and will be effective as of the date this form is signed.

Beneficiary name	Relationship to Insured	Date of birth	% of share	SSN:
Primary: 1.			%	
2.			%	
Contingent: 1.			%	
2.			%	

INSURED SIGNATURE (Required): X _____ Date: _____

WITNESS SIGNATURE (Required for new adds, reinstatements or beneficiary change): X _____ Date: _____

PLEASE READ AND COMPLETE ALL PAGES

Ullico
SOLUTIONS FOR THE UNION WORKPLACE

ENROLLMENT AND BENEFICIARY FORM

PLEASE PRINT

FRAUD NOTICE

California: For your protection California Law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: 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.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits

I attest that I have reviewed, understand and acknowledge the fraud warning(s).

Member or Claimant's signature: X _____ Date: _____

PLEASE READ AND COMPLETE ALL PAGES

Vermont Department of Taxes PO Box 547 Montpelier, VT 05601-0547 Phone: (802) 828-2551

VT Form **HC-2**	**DECLARATION OF HEALTH CARE COVERAGE**	**This form must be completed annually by all uncovered employees. Employers must retain this form for 3 years.**

Employer: This form is **only** to be completed by employees if you offer to pay a portion of a health care plan that provides hospital and physicians services to at least some of your employees. You must retain all employee declaration forms together in a file for three years and be able to produce them in the event of an audit.

Employer's Legal Name *(Please print)* IBEW Local 300 Health and Welfare

Employee: Complete and sign this form and return it to your employer. The purpose of this form is to obtain information regarding your health care coverage. The information you provide on this form will be used solely for purposes of determining if your employer must pay Health Care Contributions as required under Vermont law at 32 V.S.A § 10503.

Employee's Full Name *(Please print)*	
Employee ID or Social Security Number	**Date of Birth**

Will the employee be under the age of 18 for the entire calendar year? ☐ YES ☐ NO

If **YES**, stop. Please sign the bottom of the form and submit it to your employer.

If **NO**, please continue to complete this form and submit it to your employer.

Check the box beside the statement that best describes your health care coverage.

1. My employer offers health care coverage to me.

☐ I have accepted the health care coverage offered and provided by my employer.

2. My employer offers health care coverage to me, and I have not accepted my employer's coverage.

☐ I have health care coverage that includes hospital and physicians services from a source other than Medicaid or Vermont Health Benefit Exchange.

My coverage is provided through: _____

☐ I am a full-time employee and have health care coverage as an individual through the Vermont Health Benefit Exchange.

☐ I have Medicaid.

☐ I have no health care coverage.

3. My employer does not offer health care coverage to me.

☐ I am a part-time employee who works fewer than 30 hours per week, **and** I have coverage from a source other than Medicaid that offers hospital and physicians services.

☐ I am a seasonal employee who expects to work for this employer 20 or fewer weeks during this calendar year, **and** I have coverage from a source other than Medicaid that offers hospital and physicians services.

☐ I have health care coverage that offers hospital and physicians services.

My coverage is provided through: _____

☐ I am a part-time or seasonal employee, and I do not have health care coverage **or** I am covered by Medicaid.

☐ I have no health care coverage.

☐ **I certify the above information is accurate and true to best of my knowledge and belief.**

Employee Signature _____ Date _____

Note: If your health care coverage changes within the year, you must complete a new Declaration of Health Care Coverage.

International Brotherhood of Electrical Workers – Local 300
Health & Welfare Fund
AFL – CIO – CLC
3 Gregory Drive South Burlington, VT 05403
Telephone (802) 864-5864
Fax (802) 864-5495
www.ibewlocal300.org

Short Term Disability Enrollment Form

Requested Effective Date: _____

This form needs to be completed and signed in order to be eligible for the Short Term Disability Benefit.

Section 1 - Employee Information:

Name: _____

Address: _____

Health Coverage (check 1): ☐ Employee Only ☐ Employee/Spouse
☐ Employee/Child(ren) ☐ Family

Section 4 – Subscriber Signature

By signing below, I understand that only I, the member, am eligible for Short Term Disability Benefits through The Plan.

_____ _____

Signature **Date**

International Brotherhood of Electrical Workers – Local 300
Health & Welfare Fund
AFL – CIO – CLC
3 Gregory Drive South Burlington, VT 05403
Telephone (802) 864-5864
Fax (802) 864-5495
www.ibewlocal300.org

HSA/HRA Enrollment/Change Form

Requested Effective Date: _____

Section 1 - Employee Information:

Name: _____

Address: _____

E-mail Address: _____

Phone: _____

Health Coverage (check 1): ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Section 2 - New Enrollment (check one then go to section 4): *Please note that you are required to enroll in an HSA unless you or your dependents are not eligible for this type of account. Please contact the Fund Office if one of the following situations applies to you:*

- **Employee is eligible for Medicare**
- **Employee is on another group Medical Plan**
- **Employee has an under age 26 dependent who is not a tax dependent**

☐ Health Savings Account (HSA) -or- ☐ Health Reimbursement Account (HRA)

Section 3 – Change (check one): If you are currently enrolled in our Plan and your circumstances have changed, please select the account you would like to switch to (only at open enrollment January 1)

☒ Health Savings Account (HSA) -or- ☐ Health Reimbursement Account (HRA)

Section 4 – Subscriber Signature

_____ _____

Signature **Date**