

IBEW Local 300 Enrollment/Change Form

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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	Beneficiar	y Change	
Name of group policyh	wholder Information nolder:IBEW Local 3				umber: <u># G-3</u> ill ID:		
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Address:							
City:				State:	Zip:		
SSN:				Date of birth:			
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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.			%	
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WITNESS SIGNATURE (Required for new adds, reinstatements or beneficiary change):			1	Date:
LHFM-ULL-1137a rev 04/16	LEASE READ AND COMPLETE	ALL PAGES		



ENROLLMENT AND BENEFICIARY FORM PLEASE PRINT

FRAUD NOTICE

<u>California</u>: 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.

<u>New Jersey</u>: 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

Date:

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

Member or Claimant's signature:

PLEASE READ AND COMPLETE ALL PAGES Page 2 of 2 Vermont Department of Taxes PO Box 547 Montpelier, VT 05601-0547

Phone: (802) 828-2551

VT	Form
Η	C-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 <u>only</u> 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 I	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 <u>not</u> accepted my employer's coverage.

Ĺ	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, <u>and</u> 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 to	rue to best of my knowledge and belief.
Employee Signature	Date
Note: If your health care coverage changes within the year, you mu	st 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/Child(ren)
Family

□ Employee/Spouse

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



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HSA/HRA Enrollment/Change Form

	Requested Ef	fective Date:
Section 1 - Employee Information:		
Name:		_
Address:		-
E-mail Address:		
Phone:		
Health Coverage (check 1): Employee Only Employee/Child(ren) Family	Employee/Spouse	

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