



ENROLLMENT FORM
NORTHERN CALIFORNIA TILE INDUSTRY
HEALTH & WELFARE FUND
 P.O. Box 2500
 San Francisco, CA 94126
 (415) 986-6276

COMPLETE ALL INFORMATION—PLEASE PRINT IN INK. THE PURPOSE OF THIS FORM IS TO ENSURE THAT YOU AND YOUR ELIGIBLE DEPENDENTS CAN PARTICIPATE IN THE NORTHERN CALIFORNIA TILE INDUSTRY HEALTH & WELFARE PLAN, AND INCLUDES ENROLLMENT IN THE SELF-FUNDED MEDICAL AND DENTAL PLANS. **IF YOU WISH TO ENROLL IN AN HMO, YOU MUST ALSO COMPLETE AN APPLICATION FOR THAT HMO.** PLEASE CONTACT THE ADMINISTRATION OFFICE FOR DETAILS.

PARTICIPANT DATA

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER
MAILING ADDRESS (STREET OR P.O. BOX)			SEX
			DATE OF BIRTH
CITY	STATE/ZIP	TELEPHONE NUMBER ()	EMAIL ADDRESS

DEPENDENT DATA (FOR INFORMATION ON DEPENDENT ELIGIBILITY, PLEASE SEE OTHER SIDE.)

DEPENDENT'S NAME	RELATIONSHIP TO PARTICIPANT*	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER

*Relationship: Spouse, Child, Stepchild, Other (see other side for definition of eligible dependents).

LIFE INSURANCE

Primary Beneficiary	NAME	RELATIONSHIP
ADDRESS	TELEPHONE NUMBER	EMAIL ADDRESS
Secondary Beneficiary	NAME	RELATIONSHIP
ADDRESS	TELEPHONE NUMBER	EMAIL ADDRESS

I HEREBY DECLARE THAT ALL STATEMENTS AND ANSWERS ABOVE ARE TRUE, AND THAT THEY ARE THE BASIS ON WHICH COVERAGE MAY BE EXTENDED UNDER THE PLAN.

Employee Signature _____

Date _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use and/or disclosure of all individually identifiable health information by the Health & Welfare Trust Fund and the Plan Administrator. By signing below, I indicate that I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive information is not a health plan or health care provider, the released information may be re-disclosed and may no longer be protected by federal privacy regulations. Additionally, the following person/organization is authorized to receive private health information on my behalf:

Name _____

Relationship _____

I understand that I may establish an expiration date or revoke this authorization at any time by providing written notice to the Privacy Officer for the Trust Fund. I may refuse to sign this authorization and my refusal to sign will not affect my ability to enroll in a health plan, obtain health care treatment or payment or eligibility for benefits.

Employee Signature _____

Date _____

DEPENDENTS ELIGIBILITY

Only the following are eligible for dependents insurance:

- Your lawful spouse;
- Your natural-born child or your adopted child or child placed with you from moment of placement during adoption proceeding under the limiting age;
- Your stepchild under the limiting age who is living in your home and is chiefly dependent on you for support;
- A foster child under the limiting age.

For purposes of coverage for your dependent child, the limiting age for coverage under the Plan is:

1. the child's 19th birthday; or
2. The 25th birthday if the child is a full-time student or is finishing his/her last semester of study in any accredited high school, trade school, college or university and is chiefly dependent on you for support.

A mentally retarded or physically handicapped child who attains the limiting age while insured under the policy may be continued if the child:

1. Is chiefly dependent on you for support; and
2. Is not capable of self-sustaining employment; and
3. You give us proof of the child's handicap:
 1. Not later than 31 days after the child attains the limiting age; and
 2. Thereafter as the Trustees may require, but not more than once every two years.

Dependent eligibility begins on the later of the day you become insured under the Plan, or the day you first acquire an eligible dependent provided that you notify the Administration Office.

TO ENROLL YOUR ELIGIBLE DEPENDENTS, YOU MUST INCLUDE THE FOLLOWING DOCUMENTATION WITH THIS ENROLLMENT FORM:

- To Enroll Your Lawful Spouse: a copy of the original marriage certificate.
- To Enroll Your Natural-Born Child: a copy of the original birth certificate.
- To Enroll Your Stepchild: a copy of the original birth certificate and the marriage certificate to the biological parent.
- To Enroll Your Foster or Adopted Child: legal guardianship or court adoption papers.

Eligibility for all persons listed on the prior page are subject to all provisions and limitation of the Trust Agreement and Plan Document (as amended) as well as to any rules or regulations adopted by the Board of Trustees. No coverage is provided for a dependent while that dependent is in full-time military service.