Heating, Piping and Refrigeration Medical Fund

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Administered by
Welfare & Pension Administration Service, Inc.

ENROLLMENT FORM

Section I – General Information

Last Name	First Name	Middle Initial

Social Security Number	Date of Birth (MM/DD/YYYY)	Gender (Select One)
		☐ Male ☐ Female

Home Phone Number (include area code)	Email

Street Address	City	State	Zip

Marital Status (Select One)	Date of Marriage (if applicable)
☐ Single ☐ Married ☐ Divorced	

Section II – Heating, Piping and Refrigeration Medical Fund Enrollment Card

Note: In order to add a spouse, we must have a copy of your marriage certificate and your spouse's Social Security Card.
In order to add a child, we must have a copy of their State issued birth certificate and their Social Security Card.
If you are adding a child from a previous marriage or a stepchild, we must have a copy of their State issued birth certificate and a copy of their Social Security Card.

Dependent Name and Address	SSN	Relationship	Date of Birth	Gender (Select One)
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female

☐ Check here if you have additional dependents to list and complete the Section II Addendum on page 3.

Section III - Declaration of Health Insurance

The form below is intended to solicit information concerning other Medical Benefits which may be available to your spouse or dependent children. If that other coverage is Primary to the Fund, having this information on file will help ensure the accurate payment of the claim and maximize the benefit dollars available from your Health Fund. This information is required to be updated every 12 months. Please complete the form and return it to the Fund Office. Your assistance in this process is appreciated.

☐ Check here if **NO OTHER COVERAGE** available to you, your eligible spouse and/or dependents and sign & date this form at the bottom.

- OR -

If you, your spouse and/or dependent children have other coverage, please complete the form below and return with a copy of the other carrier's identification card.

Other Coverage Carrier Name	Policy Holder's Name
Type of Policy (Retiree Plan, Active Plan, etc.)	**Effective Date**
List who is covered and relationship to policy holder	**Type of Coverage** (select all that apply)
	☐ Medical ☐ Dental ☐ Vision ☐ Prescription Drug

Other Coverage Carrier Name	Policy Holder's Name
Type of Policy (Retiree Plan, Active Plan, etc.)	**Effective Date**
List who is covered and relationship to policy holder	**Type of Coverage** (select all that apply)
	☐ Medical ☐ Dental ☐ Vision ☐ Prescription Drug

Important: If the other coverage terminates, the Fund requires a copy of the HIPAA notice issued from the other carrier. This notice is required to be mailed upon termination.

Print Name	Member Signature	Date	SSN

Participant Signature	Date

Section II Addendum – Additional Dependents

Note: If you do not need to list additional dependents, skip this page, as it is not required.

Dependent Name and Address	SSN	Relationship	Date of Birth	Gender (Select One)
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female