

**PIPE FITTERS LOCAL UNION NO. 211**  
**WELFARE TRUST**

Benefit Resources Inc.  
P.O. BOX 87549 - HOUSTON, TEXAS 77287  
LOCAL 713- 645-1076 FAX 713-242-8662

October 1, 2021

RE: 2022 Mandatory Annual Demographic Forms Requirement

Dear Participant:

The Trust Fund requires all participants to complete an annual demographics enrollment form. Enclosed is your annual demographics enrollment form that must be completed and returned to the Fund Office by December 15, 2021. If your annual demographics form is not received, eligibility for your dependent(s) will not be sent to Trust Fund vendors.

**SPOUSAL AFFIDAVIT:** The Board of Trustees require all spouses who are enrolled in the plan and have the ability to obtain coverage through their own employer, to enroll in their employer plan. The attached certification form must be completed and turned in with the annual demographics form. If an enrolled spouse fails to enroll in their employer's plan, the spouse will be terminated from the plan. **Please note that Blue Cross Blue Shield will still require other insurance information upon receipt of the first claim for any eligible dependent.**

1. Complete 2022 Annual Demographic Form
2. If recently married, provide a certified copy of your marriage certificate and you must complete the Spousal affidavit. **If your spouse works, they are required to enroll in their employer's medical plan. If your spouse works and is not provided medical coverage through their employer's plan, you must submit a letter on company letterhead from their employer stating no insurance is provided.**
3. If common law married, provide a copy of your court approved common law marriage form and **Spousal affidavit, please see item 2 above.**
4. If enrolling your biological child(ren) for the first time, a copy of their certified birth certificate. Their birth certificate must list participant name
5. If enrolling adopted child(ren) for the first time, a copy of their certified birth certificate and a copy of the court document showing you have adopted the child(ren) being enrolled
6. If enrolling step-child(ren) for the first time, a copy of their birth certificate, copy of other insurance information, divorce decree (if applicable) from spouse's previous marriage to determine who should provide primary coverage. If step-child(ren) were not from a previous marriage, a notarized document certifying that your spouse is responsible for medical care of the step-child(ren) being enrolled.

All documentation must be received by the fund office no later than December 15, 2021. If documentation is not received coverage for your dependent(s) will not be provided during the calendar year 2022 until all documentation is received.

**Please review, complete, sign, and submit the completed form and any required documentation via email to:**

or via fax to 713-242-8662

If you have any questions concerning the required documentation, please do not hesitate to contact the Administrative Fund Office.

Thank you,  
Fund Office

## 2022 ANNUAL ENROLLMENT / DEMOGRAPHIC INFORMATION REQUEST

FOR MEMBER AND / OR DEPENDENT(S)

**BRI TOLL FREE #**  
866.236.3148  
**211 H&W PHONE #**  
713-645-1076

**RETURN  
COMPLETED  
INFORMATION TO:**



**PIPE FITTERS LOCAL 211  
WELFARE TRUST FUND**  
P.O. Box 87549  
Houston Texas 77287

**FAX # 713-242-8662**

This form must be completed and signed by the Member & Spouse before any claims will be processed.  
All questions must be answered.

**SECTION ONE - MEMBER INFORMATION**

**Check here if Change of Address**

Name		Street Address	City	State	Zip
Date of Birth	Social Security Number	Home Phone Number	Local Union #		
Email Address:					
Do you consent to receive information by email?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		<input type="checkbox"/> Widowed		
If applicable:	Date of marriage:	Date of divorce:			

**SECTION TWO - SPOUSE INFORMATION \*SPOUSAL AFFIDAVIT REQUIRED**

Spouse's Name		Mailing Address	<input type="checkbox"/> Check if same as above		
Date of Birth	Social Security Number	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Is Spouse covered under any other Dental, Vision or Group Health Plan?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, You must complete Section 3 (Other Insurance Information, below)					
Check all that apply: <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical					
Are you, your spouse or any eligible dependent(s) covered under Medicare?					
<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, who is covered by Medicare? _____			
Effective Date of Medicare : _____					

**SECTION THREE - OTHER INSURANCE INFORMATION**

Name of Insured		Insured's ID Number:			
Policy or Plan No.		Type of Coverage:		<input type="checkbox"/> Individual <input type="checkbox"/> Family	
Name, Address and Phone No. of Insurance Company:					
<b>I HEREBY DESIGNATE THE INDIVIDUAL NOTED BELOW TO RECEIVE ANY LIFE INSURANCE BENEFIT PAYABLE UNDER THE PIPE FITTERS LOCAL 211 WELFARE TRUST FUND:</b>					
Full Name			Relationship		
Address (If not the same as yours)					

**THIS FORM MUST BE DATED AND SIGNED BY YOU AND YOUR SPOUSE**

I/WE jointly certify that the information above and on the back of this form is complete, true and correct. I/WE hereby authorize all doctors, pharmacists, hospitals or other Institutions rendering care and treatment to furnish Pipe Fitters Local 211 Welfare Trust Fund with full information regarding treatment rendered (including copies of their records). I/WE also authorize any union, trust fund, employer or insurance carrier to furnish Pipe Fitters Local 211 Welfare Trust Fund with information regarding benefits to which I/WE may be entitled. A copy or photocopy of this authorization shall be considered as effective and valid as the original.

Date	MEMBER'S SIGNATURE	SPOUSE'S SIGNATURE
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Please provide the requested information, on the back of this form, on all family members who are covered under the Plan. Please make a copy of the back of this form if more than three dependents.

Dependent's Name		Date of Birth	Social Security Number	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent's Address				
Relationship to Member: <input type="checkbox"/> Child <input type="checkbox"/> Step Child (for whose health coverage You or your eligible spouse is responsible) <input type="checkbox"/> Foster Child or other Child of whom you are the legal guardian		Is dependent <u>eligible</u> for Health coverage through an employer (other than the employer of the dependent's parent) even if not enrolled in that coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If age 26 or older, then dependent is not eligible to participate in the Welfare Trust unless dependent is (i) unable to support himself because of a disability that occurred before his 26 <sup>th</sup> birthday, and (ii) has never married, and (iii) is otherwise eligible under the terms of the Plan.		
Dependent lives with: _____ Has Child ever been married? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of marriage _____		Is dependent <u>covered</u> under any other Dental, Vision or Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Check all that apply: <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical If yes, you must complete the following: Name of Insured _____ Group or Plan No. _____		
Is dependent incapable of self-support due to a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		Insured's ID No. _____ Type of Coverage <input type="checkbox"/> Family <input type="checkbox"/> Individual Name, address, & phone number of Insurance Company: _____		

Dependent's Name		Date of Birth	Social Security Number	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent's Address				
Relationship to Member: <input type="checkbox"/> Child <input type="checkbox"/> Step Child (for whose health coverage You or your eligible spouse is responsible) <input type="checkbox"/> Foster Child or other Child of whom you are the legal guardian		Is dependent <u>eligible</u> for Health coverage through an employer (other than the employer of the dependent's parent) even if not enrolled in that coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If age 26 or older, then dependent is not eligible to participate in the Welfare Trust unless dependent is (i) unable to support himself because of a disability that occurred before his 26 <sup>th</sup> birthday, and (ii) has never married, and (iii) is otherwise eligible under the terms of the Plan.		
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Is dependent incapable of self-support due to a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		Insured's ID No. _____ Type of Coverage <input type="checkbox"/> Family <input type="checkbox"/> Individual Name, address, & phone number of Insurance Company: _____		

Dependent's Name		Date of Birth	Social Security Number	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent's Address				
Relationship to Member: <input type="checkbox"/> Child <input type="checkbox"/> Step Child (for whose health coverage You or your eligible spouse is responsible) <input type="checkbox"/> Foster Child or other Child of whom you are the legal guardian		Is dependent <u>eligible</u> for Health coverage through an employer (other than the employer of the dependent's parent) even if not enrolled in that coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If age 26 or older, then dependent is not eligible to participate in the Welfare Trust unless dependent is (i) unable to support himself because of a disability that occurred before his 26 <sup>th</sup> birthday, and (ii) has never married, and (iii) is otherwise eligible under the terms of the Plan.		
Dependent lives with: _____ Has Child ever been married? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of marriage _____		Is dependent <u>covered</u> under any other Dental, Vision or Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Check all that apply: <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical If yes, you must complete the following: Name of Insured _____ Group or Plan No. _____		
Is dependent incapable of self-support due to a disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		Insured's ID No. _____ Type of Coverage <input type="checkbox"/> Family <input type="checkbox"/> Individual Name, address, & phone number of insurance Company: _____		

Note: It may constitute fraud and/or grounds for immediate and retroactive termination of coverage to: (i) provide inaccurate or incomplete information on this form, (ii) enroll an ineligible spouse or dependent, or (iii) fail to contact the Welfare Trust once your spouse or dependent is no longer eligible to participate in the Welfare Trust Fund.

You must provide any documentation that the Welfare Trust Fund reasonably requires in order to substantiate that your spouse, child, or other dependent is eligible to participate in the Welfare Trust. Fund If you have questions regarding the eligibility of your spouse, child, or other dependent, contact the Welfare Trust Fund at (713) 643-9300 or (866) 236-3148.

## Spousal Affidavit – Must be completed by Spouse

As the legal spouse of a Pipe Fitters Local 211 Trust Fund participant, in order to be covered under the medical plan during plan year starting January 1, 2022, you must sign and return this Spousal Affidavit with your spouse annual demographics form.

Please check the appropriate box below and certify that I am:

- I am not employed or I am Retired with no ability to obtain insurance coverage
- I am Self-employed with no ability to obtain insurance benefits
- I am Employed but my employer does not offer group health plan coverage. You must provide proof from your employer.
- I am enrolled in group health plan coverage through my employer.  
If you check this box, please provide the information requested below.

I also certify under penalty of perjury under the laws of the State of Texas that the foregoing is true and correct. I understand that providing false information or concealing important facts can be considered a violation of the law and punishable by a fine, imprisonment, or both and that I may be required to repay to the Plan any benefits improperly paid on my behalf.

Spouse Name (Please print): \_\_\_\_\_

Spouse Signature: \_\_\_\_\_ Date \_\_\_\_\_

Member Name (Please print): \_\_\_\_\_

Member Signature: \_\_\_\_\_ Date \_\_\_\_\_

*If you have any questions about spousal eligibility status, contact Benefit Resources Inc. before signing this document. Please note:*

- *The Plan reserves the right to request at any time documentation that substantiates the eligibility of an enrolled spouse.*
- *The Plan has the right to request reimbursement of any premiums and claims paid for ineligible spouses.*
- *Failure to complete this Spousal Affidavit fully and truthfully will make the spouse ineligible for Trust Fund health plan coverage during 2022*

### **Complete if You Have Health Plan Coverage through Your Employer**

If you are enrolled in group health plan coverage through your employer, please provide the following information:

Employer Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group Number and ID Number \_\_\_\_\_

Effective Date: \_\_\_\_\_