ENROLLMENT FORM

This form must be completed in full by our member and submitted to the Fund Office, along with all necessary documents (see attached).
If you have a dependent child age 19 up to age 26, please complete and submit an "Adult Child Eligibility Form".
All family member names listed must match with the Social Security Administration!

It is important for the continued coverage of you and your family that we be informed of any changes in this information.

Section 1: Member Information

Names must match with the Social Security Administration.

Last Name:	First:	Middle Initial:	Social Security Number:

Date of Birth:	Home Address:

Home Phone:	Cell Phone:	City:	State:	Zip Code:

Gender:	Employer:	Job Title:	Date Employed:
○ Male ○ Female			

Marital Status: ○ Single ○ Married ○ Widowed ○ Divorced ○ Legally Separated

Section 2: Beneficiary Information

Life Insurance and/or Accidental Death and Dismemberment Insurance

All Primary must equal 100%
All Secondary must equal 100%

Last Name, First, Middle Initial:	Date of Birth:	% of Benefit
Address, City, State, Zip:		○ Primary ○ Secondary
Last Name, First, Middle Initial:	Date of Birth:	% of Benefit
Address, City, State, Zip:		○ Primary ○ Secondary
Last Name, First, Middle Initial:	Date of Birth:	% of Benefit
Address, City, State, Zip:		○ Primary ○ Secondary
Last Name, First, Middle Initial:	Date of Birth:	% of Benefit
Address, City, State, Zip:		○ Primary ○ Secondary

Section 3: Spouse Information

If adding spouse include copy of marriage license.

Last Name:	First:	Middle Initial:	Social Security Number:

Gender: ○ Male ○ Female	**Names must match with the Social Security Administration.**	Date of Birth:
Is Spouse Employed: ○ No ○ Yes	Employers Name:	Date of Marriage:

Does spouse have medical coverage through their own employment?	Does spouse have dental coverage through their own employment?	Does spouse have a HRA, FSA or HAS with this coverage?
○ No ○ Yes*	○ No ○ Yes*	○ No ○ Yes
Is Yes, complete Section 5.	If Yes, complete Section 6.	

I/We jointly certify that the above information is true and correct and that any incorrect or inaccurate information can result in a loss of benefits. I/We hereby authorize doctors, pharmacists, hospital, or other institutions rendering care and treatment to furnish District No. 9 I.A. of M. and A. W. Welfare Trust with full information regarding treatment rendered (including copies of records). I/We also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish District No. 9, I.A. of M. and A.W. Welfare Trust with information regarding benefits to which I/We may be entitled. A photo static copy of this authorization shall be considered as effective and valid as the original, and shall remain in effect for a period of one year.

Member Signature:_____ Spouse Signature:_____ Date:_____

DISTRICT NO. 9, I. A. OF M. & A. W. WELFARE TRUST
12365 St. Charles Rock Road ■ Bridgeton, MO 63044
(314) 739-6442 ■ (888) 739-6442 ■ fax (314) 739-2374 ■ www.d9trusts.org

Section 4:

Dependent Information

List your children under age 19. Include with this form a copy of each child's birth certificate, social security card and if applicable, any legal documents. Must include copy of all other insurance cards.

<u>Adult children aged 19 up to age 26 must complete the "Adult Child Eligibility Form".</u>

Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		
Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		
Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		
Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		
Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		
Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		
Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		
Last Name:	First:	Middle Initial:	Social Security Number:	Date of Birth:
Gender: ○ Male ○ Female	Relationship to Member: ○ Child ○ Step-Child ○ Other, Explain			
Covered by Other Medical Insurance: ○ No ○ Yes		Covered by Other Dental Insurance: ○ No ○ Yes		

Section 5:

Other Medical Insurance Information

Medical Carrier Name:	Insured Person's Name:
List Name(s) of Each Family Member Covered by this Other Medical Plan:	Effective Date of Coverage:
You must include a copy of all other insurance cards, including Medicare.	
List Name(s) of Each Family Member on <u>Medicare</u>:	

Section 6:

Other Dental Insurance Information

Dental Carrier Name:	Insured Person's Name:
List Name(s) of Each Family Member Covered by this Other Dental Plan:	Effective Date of Coverage:
You must include a copy of all other insurance cards.	

Documents Required For Enrollment

An Enrollment Form must be completed by all new members or to add a dependent to your plan. The fully completed form must be submitted to the Fund Office with any required documentation. Failure to do so in a timely fashion may result in a delay to activate your benefits. It is important for your continued coverage that we be informed of any changes in your information.

All family member names listed must match with the Social Security Administration!

ENROLLING EMPLOYEE ONLY

- Clear copy of Social Security Card
- Fill out an Enrollment Form.

ENROLLING EMPLOYEE AND SPOUSE ONLY or TO ADD A NEW SPOUSE

- Fill out an Enrollment Form.
  - Clear copy of Social Security Card
  - Include a copy of your marriage license.

ENROLLING ONE OR MORE CHILDREN (newborn through age 18)

- Fill out an Enrollment Form and include copies of the following documents.
  - **Dependent Child from your current marriage**
    - Birth Certificate of child
    - Clear copy of Social Security Card
  - **Dependent Child or Stepchild from a Previous Marriage**
    - Clear copy of Social Security Card
    - Birth Certificate of child
    - The Divorce Decree & Settlement of the natural parents including the petitioner and respondent page, the page showing child's name, page showing custody, page showing who has to maintain insurance (if applicable) and the judges and parents signature page.
  - **Child Born Outside of Marriage**
    - Clear copy of Social Security Card
    - Birth Certificate of child or Court Order regarding Insurance. Along with the name and date of birth of the other natural parent, including information regarding any other insurance coverage.
  - **Child for Which You are Guardian**
    - Clear copy of Social Security Card
    - Guardianship / Custody documents.
  - **Adopted Child**
    - Clear copy of Social Security Card
    - Final Adoption Papers and Birth Certificate of Child.

ENROLLING ONE OR MORE ADULT CHILDREN (age 19 up to age 26)

- Fill out an Adult Child Eligibility Form
  - Clear copy of Social Security Card
  - Include copy of Birth Certificate

NOTE:

- **You have 30 days after your dependent first becomes eligible to provide the required documentation to the Fund Office. After that time, they will be effective for insurance coverage on the date that we receive all necessary paperwork. Please call the District No. 9 Welfare Office at 314-739-6442 or 888-739-6442 if you have any questions.**

District No. 9, Welfare Trust
12365 St. Charles Rock Road – Bridgeton, Missouri 63044
Phone: 314-739-6442 • Toll Free: 888-739-6442 • Fax: 314-739-2374 • www.d9trusts.org

Nondiscrimination Notice

The District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters, and
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters, and
  - Information written in other languages.

If you need these services, contact David DeJarnett, Director of Operations.

If you believe that The District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

David DeJarnett, Director of Operations
12365 St. Charles Rock Rd.
Bridgeton, MO 63044
Phone: 314-739-6442 ▪ Fax: 314-739-2374 ▪ ddejarnett@d9trusts.org

You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, Director of Operations David DeJarnett is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1–800–868–1019, 800–537 7697(TDD).Complaint forms are available at: *http://www.hhs.gov/ocr/office/file/index.html*.

(English) ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-314-739-6442	(Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-314-739-6442
(Spanish) ATENCIÓN: si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-314-739-6442	(Arabic) رقم (314-739-6442- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (xxx-xxx-xxxx- هاتف الصم والبكم: 1
(German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-314-739-6442	(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-314-739-6442
(French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-314-739-6442	(Pennsylvania Dutch) Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-314-739-6442 (TTY: 1-314-739-6442).
(Chinese) 注意：如果您使用繁體中文 您可以免費獲得語言援助服務。請致電 1-314-739-6442	(Persian [Farsi]) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 1-314-739-6442 فراهم می باشد. با تماس بگیرید.
(Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-314-739-6442	(Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-314-739-6442
(Serbo-Croatian) OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-314-739-6442	(Amharic) ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-314-739-6442
(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-314-739-6442	(Cushite – Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-314-739-6442