



Statement of HIPAA Portability Rights

This page to be retained by employee

TPM Trust Privacy Policy

We may collect, use or disclose personal information about you, including health information, your address, telephone number or Social Security number. We may receive this information from, or release it to, healthcare providers, insurance companies, or other sources to conduct our routine business operations such as: underwriting and determining your eligibility for benefits and paying claims; coordinating benefits with other healthcare plans; conduction care management, case management, or quality reviews. This information may also be collected, used or released as required or permitted by law.

To safeguard your privacy and ensure your information remains confidential, we train all employees on our written privacy policy and procedures. If a disclosure of your personal information is not related to a routine business function, we will remove anything that could be used to easily identify you, unless we have your prior authorization to release such information.

You have the right to request inspection and/or amendment of your records retained by us.

To view or print copies of our detailed Privacy Notice and other forms, please visit our website at www.timberassociation.com.

Special Enrollment Rights

If you are declining enrollment for yourself or dependents (including your spouse) because of other healthcare coverage, you may in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended (60 days if the prior coverage was through Medicaid or CHIP). Additionally, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and dependents, provided we receive your completed enrollment application within 60 days after the marriage, birth, adoption, or placement for adoption, unless a different time limit has been specified in your benefit booklet.

Late Enrollees

A "Late Enrollee" is an individual or family dependent who did not enroll when first eligible for coverage under this plan and does not qualify as a Special Enrollee. If you or your dependents are Late Enrollees, you or your dependents may enroll during the next occurring Annual Group Open Enrollment.

Creditable Coverage

"Creditable Coverage" means prior or ongoing healthcare coverage including any group healthcare coverage (including the Federal Employees Health Benefits Plan and the Peace Corps), individual healthcare coverage (including student health plans), Medicare, Medicaid, CHAMPUS, Indian Health Service or tribal organization coverage, state high-risk pool coverage, state Children's Health Insurance Program (CHIP), a public health plan established or maintained by a State, the U.S government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

GINA HEALTH STATEMENT DISCLAIMER

Pursuant to the requirements of the Genetic Information Non-Discrimination Act (GINA), the information being requested in this form is being used only in the process of establishing rates for the person to whom the requested information applies and it is not used for any other purpose or applied to any other individual listed on this application for any purpose.



TPM TRUST ADD/DROP/CHANGE FORM

To employee: Please complete this form as completely as possible. If you need more room for dependents, use page 4. You can type it on the computer and then print and sign the completed form. Or print it and fill it out by hand. Return to your HR department or if directed you may return it TPM to:
TPM Trust ▲ 951 East Third Avenue, Spokane, WA 99202 ▲ Toll Free 877-535-4646 ▲ TPM Trust Secure Fax 509-533-1947

Employer/Company Name _____

New Enrollee Rehire Enrollee Date of Hire/Rehire _____

If this is a change, indicate what type: Name Address If other explain _____

EMPLOYEE

First _____ Initial _____ Last _____ Male Female Date of Birth _____

Mailing Address _____ City _____ State _____ Zip Code _____ Social Security Number or Worker ID Number _____

Primary Phone _____ Secondary Phone _____ E-mail Address _____

- Add MEDICAL Add DENTAL Add VISION Add LIFE Add SHORT TERM DISABILITY
- Drop MEDICAL Drop DENTAL Drop VISION Drop LIFE Drop SHORT TERM DISABILITY

Change Plan Coverage to: _____

WAIVING COVERAGE If WAIVING COVERAGE proceed to page 3, signature required.

SPOUSE / PARTNER

First _____ Initial _____ Last _____ Male Female Date of Birth _____

Spouse Domestic Partner Date of Marriage _____ Date of Divorce _____ Social Security Number or Worker ID Number _____

Address if Different from Employee _____ City _____ State _____ Zip Code _____ Primary Phone if Different from Employee _____

- Add MEDICAL Add DENTAL Add VISION Add LIFE Add SHORT TERM DISABILITY
- Drop MEDICAL Drop DENTAL Drop VISION Drop LIFE Drop SHORT TERM DISABILITY

E-mail Address _____

CHILD/DEPENDENT

First _____ Initial _____ Last _____ Male Female Date of Birth _____

Address if Different from Employee _____ City _____ State _____ Zip Code _____ Social Security Number _____

- Add MEDICAL Add DENTAL Add VISION Drop MEDICAL Drop DENTAL Drop VISION

Relationship to Employee _____

CHILD/DEPENDENT

First _____ Initial _____ Last _____ Male Female Date of Birth _____

Address if Different from Employee _____ City _____ State _____ Zip Code _____ Social Security Number _____

- Add MEDICAL Add DENTAL Add VISION Drop MEDICAL Drop DENTAL Drop VISION

Relationship to Employee _____

CHILD/DEPENDENT

First _____ Initial _____ Last _____ Male Female Date of Birth _____

Address if Different from Employee _____ City _____ State _____ Zip Code _____ Social Security Number _____

- Add MEDICAL Add DENTAL Add VISION Drop MEDICAL Drop DENTAL Drop VISION

Relationship to Employee _____

QUESTIONS

Please answer the following questions and complete any corresponding sections.

- 1. Is any dependent child, age 26 or older, eligible because of a disability? Yes No If yes, complete and attach the Request for Certification Disabled Dependent form.
- 2. Have you and/or your dependents been covered by the TPM Trust in the past two years? Yes No If no, what company were you covered through (employer)? _____
- 3. Will any applicant have other active health coverage (including Medicare or Medicaid)? Yes No If yes, please complete Other Health Insurance Information section below.

OTHER HEALTH INSURANCE INFORMATION

Other Health Insurance Information

Please DO NOT include coverage this plan is replacing unless you will continue to be covered under your existing plan.

Other Insurance Name _____

Company Address _____

City _____ State _____ Zip Code _____

Policy Holder Name _____

Policy # or Social Security Number _____ Date of Birth _____

Check coverage that is currently being provided elsewhere. MEDICAL DENTAL VISION PHARMACY

List below individuals enrolled in other coverage.

First _____ Last _____ Date Coverage Ends _____

First _____ Last _____ Date Coverage Ends _____

First _____ Last _____ Date Coverage Ends _____

First _____ Last _____ Date Coverage Ends _____

Medicare/Medicaid

If you and/or your dependents are enrolled in Medicare Part A, B, and/or D or Medicaid, please complete the following:

First _____ Last _____	Medicare Part A Effective Date _____	Medicare Part B Effective Date _____	Medicare Part D Effective Date _____	Medicaid Effective Date _____
First _____ Last _____	Medicare Part A Effective Date _____	Medicare Part B Effective Date _____	Medicare Part D Effective Date _____	Medicaid Effective Date _____

BENEFICIARY INFORMATION

Life Insurance Coverage Information

Complete the Beneficiary Information for Life Insurance.

Employee Occupation/Job Title _____ Gross Earnings \$ _____ Per year

Beneficiary First Name _____ Initial _____ Last _____ Date of Birth _____ Social Security Number _____

Mailing Address _____ City _____ State _____ Zip Code _____ Beneficiary Relationship to Employee _____

REQUIRED

- I understand that providing inaccurate information or incorrect information to any of the questions on this Enrollment/Drop Form may be considered health care fraud.
- I acknowledge receipt of the HIPAA Portability Rights statement furnished to me with this form.

When you have completed the form, click on print. Then sign and date the form and return to your employer.

Signature of Applicant

Date

TO BE FILLED OUT BY EMPLOYER

Plan Name(s) _____ Based on your current joinder, what is the effective date? _____

Group Number _____ Division or Location _____ Department _____



WAIVING COVERAGE

To employee: Please complete this form if you do not want to be covered under your employer's health care coverage. You can type it on the computer and then print and sign the completed form. Or print it and fill it out by hand. Return to your HR department or if directed you may Return it TPM to: TPM Trust ▲ 951 East Third Avenue, Spokane, WA 99202 ▲ Toll Free 877-535-4646 ▲ TPM Trust secure fax at 509-533-1947

WAIVING COVERAGE

First _____ Initial _____ Last _____

I DECLINE to enroll in the health coverage for myself.

I DECLINE coverage because I have other coverage.
Name of Coverage

I DECLINE to enroll in the health coverage for spouse/partner.

I DECLINE to enroll in the health coverage for my dependent child/children.

Other Reason for declining coverage

Please list individuals that will be effected by this waiver. (Dependents)

I UNDERSTAND THAT THIS WAIVER OF COVERAGE MAY AFFECT THE ABILITY OF EACH PERSON LISTED ABOVE TO OBTAIN COVERAGE AT A LATER DATE. Specifically, except during applicable "Special Enrollment Periods," each person listed above may be considered to be a Late Enrollee, and subjected to an exclusionary period of up to eighteen (18) months [12 months for Oregon domiciled employers, 3 months for Washington domiciled employers with 51 or more employees, 9 months for Washington domiciled employers with less than 51 employees] for any pre-existing condition, as that term is defined by Federal law (HIPAA).

Signature of Employee

Date

Signature of Spouse/Partner
(If spouse/partner is waiving coverage)

Date

When you have completed the form, click on print. Then sign and date the form and return to your employer.



TPM TRUST ADD/DROP/CHANGE FORM Additional Dependents

CHILD/DEPENDENT First _____ Initial _____ Last _____ Male Female Date of Birth _____

Address if Different from Employee _____ City _____ State _____ Zip Code _____ Social Security Number _____

Add MEDICAL Add DENTAL Add VISION Drop MEDICAL Drop DENTAL Drop VISION Relationship to Employee _____

CHILD/DEPENDENT First _____ Initial _____ Last _____ Male Female Date of Birth _____

Address if Different from Employee _____ City _____ State _____ Zip Code _____ Social Security Number _____

Add MEDICAL Add DENTAL Add VISION Drop MEDICAL Drop DENTAL Drop VISION Relationship to Employee _____

CHILD/DEPENDENT First _____ Initial _____ Last _____ Male Female Date of Birth _____

Address if Different from Employee _____ City _____ State _____ Zip Code _____ Social Security Number _____

Add MEDICAL Add DENTAL Add VISION Drop MEDICAL Drop DENTAL Drop VISION Relationship to Employee _____

CHILD/DEPENDENT First _____ Initial _____ Last _____ Male Female Date of Birth _____

Address if Different from Employee _____ City _____ State _____ Zip Code _____ Social Security Number _____

Add MEDICAL Add DENTAL Add VISION Drop MEDICAL Drop DENTAL Drop VISION Relationship to Employee _____

CHILD/DEPENDENT First _____ Initial _____ Last _____ Male Female Date of Birth _____

Address if Different from Employee _____ City _____ State _____ Zip Code _____ Social Security Number _____

Add MEDICAL Add DENTAL Add VISION Drop MEDICAL Drop DENTAL Drop VISION Relationship to Employee _____