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

Employer/Company Name ______

☐ New Enrollee ☐ Rehire Enrollee Date of Hire/Rehire ______

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

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

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 Portabiltiy 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 to enroll in the health coverage for spouse/partner.

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

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

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 Date
(If spouse/partner is waiving coverage)

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 ______