ENROLLMENT/APPLICATION FORM AND/OR WAIVER OF COVERAGE FOR GROUP HEALTH INSURANCE

Timber Products Manufacturers Trust

951 East Third Avenue
Spokane, WA 99202-2287
(877) 535-4646 phone
(509) 533-1947 fax
www.tpmrs.com

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.

Statement of HIPAA Portability Rights

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.

Timber Products Manufacturers Trust
951 East Third Avenue, Spokane, WA 99202

Employee Name: _____

ENROLLMENT/APPLICATION FORM AND/OR WAIVER OF COVERAGE FOR TPM GROUP HEALTH PLAN

Coverages Electing: (Check All That Apply)

☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Disability** ☐ **Life**

Employee

Employer Name:	**Employer Group No.**	**Date of Hire: / /**
First Name:	Middle Initial:	Last Name:
Date of Birth (M/D/Y): / /	Social Security Number:	
Mailing Address:		**Sex: M F** *circle one*
City:	State:	Zip:
Daytime Phone Number: ( )	Email:	
Employee Occupation/Job Title:	Earnings: (for Disability or Life Ins.) $	Per

Life Insurance Information

Beneficiary First Name:	Middle Initial:	Last Name:
Date of Birth (M/D/Y): / /	Social Security Number:	
Mailing Address:		
City:	State:	Zip:
Phone Number: ( )	Relationship:	

Spouse/Dependents

(Use additional paper if necessary) **MARITAL STATUS: (check applicable box)** ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED**

First Middle Last	Social Security Number	Date of Birth	Sex M/F	Relationship	Resides With Employee Y/N	To Be Covered Y/N
LEGAL SPOUSE Marriage Date: / /						
List Child						
List Child						
List Child						
List Child						
List Child						

Does a dependent have a different mailing address? *(circle)* **No** **Yes** If yes, complete the following:
Dependent's Name (Last, First, MI) _____
Dependent's mailing address: _____ City: _____ State: _____ Zip: _____

Is any child over the dependent age limit due to a disability? *(circle)* **No** **Yes**
If yes complete and attach the Request for Certification Disabled Dependent form.

Has any applicant had health insurance coverage at any time during the past 63 days before your enrollment date on this plan? *(circle)* **No** **Yes**
(If credible coverage information is not provided, the full waiting period will apply.)
If yes, who was covered? *(circle)* **Employee** **Spouse** **Dependent** **Children** Date coverage began ___/___/___ Date Coverage ended ___/___/___

Will any applicant have other current health coverage including Medicare or Medicaid? *(circle)* **No** **Yes**
If yes, please complete other health insurance information section on next page.

In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. ***Please note:*** *It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.*

_____ _____
SIGNATURE OF APPLICANT DATE

Plan #_____ Dept: _____ Effective Date: _____

Timber Products Manufacturers Trust
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Employee Name: _____

COMPLETE WAIVER FORM IF YOU AND/OR YOUR DEPENDENTS CHOOSE NOT TO BE COVERED BY THIS HEALTH PLAN.

Waiving Coverage

I **decline** to enroll in the health coverage for: *(check applicable boxes)*

☐ **Myself** ☐ **My Spouse** ☐ **My Dependent Child/Children** *(please list all individuals waiving)*

Reason for waiver: **Other coverage** **Other reason (explain)**_____

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).

EMPLOYEE'S SIGNATURE: _____ DATE _____

SPOUSE'S SIGNATURE: _____ DATE _____
(if Spouse is waiving coverage)

Other Health Insurance Information

Other Health Coverage? ☐ **YES (if yes, complete section below)** ☐ **NO**
(* Please do not include coverage this plan is replacing unless you will continue to be covered under your existing plan.)

Please check the coverage currently being provided elsewhere: ☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Pharmacy**
List all family members, including yourself, who are covered by other health coverage at the present time:

SELF ☐ YES ☐ NO	**SPOUSE** ☐ YES ☐ NO	**CHILD/CHILDREN** ☐ YES ☐ NO

If you checked **YES**, please list dependents below:

Spouse: Coverage ends: / /	Child: Coverage ends: / /
Child: Coverage ends: / /	Child: Coverage ends: / /
Child: Coverage ends: / /	Child: Coverage ends: / /

Provide name, phone number and address of your other insurance company:	Policy/Certificate Number:	Effective Date:
Policyholder's Name:	Social Security Number:	Date of Birth:

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

Enrollee's name(s):	Medicare/Medicaid ID#:	Medicare Part A Effective Date:	Medicare Part B Effective Date:	Medicare Part D Effective Date:	Medicaid Effective Date:

Have you and/or your dependents been covered by a plan administrated by Timber Products Manufacturers Trust in the past two years?
YES **NO** ***(if yes, please complete section below)***

Group Name:	**Group Number:**

PLEASE NOTE: FORM NEEDS TO BE SUBMITTED TO TPM WITHIN 60 DAYS OF EFFECTIVE DATE