Timber Products Manufacturers Trust
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ENROLLMENT/ENROLLMENT CHANGE APPLICATION FORM AND/OR WAIVER OF COVERAGE FOR GROUP HEALTH INSURANCE

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.

"Please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic diseases for which any individual may be at risk."

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; conducting 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 will not be able to enroll yourself or your dependents in this plan prior to the next Open Enrollment period unless you experience a special enrollment event. To have a special enrollment event, 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 employee or family dependent who did not enroll when first eligible for coverage under this plan and does not qualify under a special enrollment event. If you or your dependents are Late Enrollees, you or your dependents may only enroll during the next occurring Annual Group Open Enrollment.

TPM TRUST

Timber Products Manufactures Trust
951 E 3rd Ave, Spokane, WA 99202

Employee Name: _____

Enrollment/Enrollment Change Application Form and/or Waiver of Coverage for the TPM Group Health Plan

Company Information - Required

Company Name:	Division:	Group Number:

Indicate Type of Form:

Enrollment Form Complete Sections: A, C, D, E, G, H, I, J ☐	Enrollment Change Form Complete Sections: B, C, D, E, F, G, H, I, J ☐

Effective Date: *Only complete sections listed above for the indicated form that pertain to the individual enrollee*

Section A: Enrollment Reason

☐ New Hire ☐ Rehire ☐ Loss of Coverage ☐ Marriage ☐ Newborn ☐ Other: _____

Section B: Enrollment Change - Check all that apply

☐ **Name Change** - Indicate PRIOR name so we can correctly identify you: _____ ☐ **Add Dependent** ☐ **Drop Dependent**

☐ **Drop Coverage** ☐ **Beneficiary Change** ☐ **Address Change** ☐ **Plan Change** - Indicate New Coverage Plan Name: _____

A waiver form must be completed if member is waiving coverage, dropping coverage or dropping dependent coverage - Located in Section H

Section C: Employee Information

Date of Hire: ☐ **Medical** - Plan Name: _____ ☐ **Dental** ☐ **Vision** ☐ **Disability** ☐ **Life**

First Name:	Middle Initial:	Last Name:
Date of Birth (MM/DD/YYYY):	**Social Security Number:**	
Mailing Address:		**Sex:** ☐ M ☐ F
City:	**State:**	**Zip Code:**
Phone Number:	**Email:**	
Occupation/Job Title:	**Earnings:** (for Disability or Life Ins.) $	**Per:**

Section D: Beneficiary Life Insurance Information

First Name:	Middle Initial:	Last Name:
Date of Birth (MM/DD/YYYY):	**Social Security Number:**	
Mailing Address:		
City:	**State:**	**Zip Code:**
Phone Number:	**Relationship:**	

Section E: Spouse/Dependent Information

Marital Status: ☐ **Single** ☐ **Married** ☐ **Domestic Partnership** - Additional Documentation Required

	Name: First	Middle Initial	Last	Social Security Number	Date of Birth	Sex: M/F	Resides With Employee Y/N	Coverage Elections Y/N Med	Den	Vis
Legal Spouse Marriage Date:										
Child Dependent:										
Child Dependent:										
Child Dependent:										
Child Dependent:										
Child Dependent:										

Any children listed above must be either: **1)** Your natural child or your legally adopted child or **2)** Your stepchild or any other child who meets the definition of a dependent as defined in the TPM Summary Plan Document.

Section F: Enrollment Add/Drop Reason

REASON FOR ADD - Indicate below	DATE OF EVENT	REASON FOR DROP - Indicate below	DATE OF EVENT
☐ **Newborn** **Date of Birth:**		☐ **Ineligible Dependent** - Reason: _____	
☐ **Adoption** - Attach Proof		☐ **Medicare/Medicaid -** *Complete Waiver Section H*	
☐ **Marriage** **Date of Marriage:**		☐ **Divorce or Legal Separation** *Section E must be completed with spousal information*	
☐ **Medical Support Notice** - Attach Proof			
☐ **Loss of Coverage** **Date of Loss:**		☐ ***Waiving Coverage*** *If waiving coverage for self and/or dependents Waiver Section H must be completed*	
☐ **Open Enrollment** **Renewal Date:**			
☐ **Other:** _____		☐ Other: _____	

Section G: Additional Enrollment Information

Does the dependent(s) have a different mailing address? ☐ **NO** ☐ **YES -** *If YES, complete the following information below:*

Dependent Name: _____

Dependent Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Is any child being enrolled over the dependent age limit of 26 due to a disability? ☐ **NO** ☐ **YES -** *If Yes, contact TPM for Request for Certification Disabled Dependent form*

Will any applicant have other current health coverage including Medicare or Medicaid? ☐ **NO** ☐ **YES -** *If Yes, please complete "Other Health Insurance Information" located in Section J*

Section H: Waiving Coverage

A waiver form must be completed if member is waiving coverage for themselves, spouse or child(ren), dropping coverage or dropping dependent coverage

I decline to enroll in health coverage for:

☐ **Myself** ☐ **My Spouse** ☐ **My Dependent Child(ren) -** *Please list below*

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Reason for Waiver:

☐ **The existence of other coverage** ☐ **Other** - *(Explain Reason)* _____

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 will be required to wait until the Group's next annual open enrollment period.

Section I: Signature and Date

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.

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.

_____ _____

Applicant Signature **Date**

FORMS MUST BE SUBMITTED TO TPM WITHIN 60 DAYS OF EFFECTIVE DATE

Section J: Other Health Insurance Information

Does any listed Applicant have other Health coverage?

☐ NO ☐ YES - *If YES, complete sections below*

** Please do not include coverage this plan is replacing unless applicant will continue to be covered under their existing plan*

Please indicate which coverages that are currently being provided elsewhere: ☐ Medical/RX ☐ Dental ☐ Vision

Please indicate which family members are currently covered by other health coverage at the present time:

☐ Myself ☐ Spouse ☐ Child(ren)

Please indicate coverage end dates for covered family members:

Myself: _____ End Date: _____ Child: _____ End Date: _____

Spouse: _____ End Date: _____ Child: _____ End Date: _____

Child: _____ End Date: _____ Child: _____ End Date: _____

Child: _____ End Date: _____ Child: _____ End Date: _____

Name of other Health Insurance Company:	Policy/Certificate Number:	Effective Date:
Policy Holder's Name:	Social Security Number:	Date of Birth:

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

List Enrollee(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 dependent(s) been covered by a plan administrated by Timber Products Manufacturers Trust in the past two years?

☐ NO ☐ YES - *If Yes, please complete the section below*

Group Name:	Group Number: