NORTHWEST INSULATION WORKERS WELFARE TRUST
INFORMATION VERIFICATION FORM

F55

BILLINGS, MT

1) Read the reverse side of this form for complete instructions.
2) Carefully review the pre-populated information below.
3) Complete the Other Insurance section; attach a separate sheet of paper if more room is needed to list additional insurance information.
4) **Sign and date the form.**
5) Attach copies of marriage and birth certificates for any listed dependents.

IMPORTANT: Please carefully review the prepopulated information below. If corrections are needed, use black or blue ink, line out the incorrect data and clearly print updated information immediately below the crossed out information. If a spouse or stepchild is listed who is no longer your spouse or stepchild, you must submit a copy of your divorce decree and parenting plan if applicable.

EMPLOYEE INFORMATION

Last Name, First Name, MI	Social Security Number	Date of Birth	M / F
	XXX-XX-	/29/	M

Mailing Address	City	State	Zip Code	Is this a change of address? ☐ Yes ☐ No
	BILLINGS	MT		

Phone Number: _____ Email Address: _____

DEPENDENT INFORMATION The Plan requires documentation for all dependents: Spouse – certified marriage certificate; child(ren) – certified birth certificate, legal guardianship, court order, and/or if adult child is married, a marriage certificate. Relationship to Subscriber Codes: S = Spouse; C = Natural Child/Stepchild/Adopted Child/Legal Guardianship of Child.

Last Name, First Name, MI	M/F	Date of Birth	Social Security Number	Relationship to Subscriber	Other Coverage? Yes / No
	F	/11/	XXX-XX-	SPOUSE	Y

OTHER INSURANCE INFORMATION

1. Are you, or your spouse, or other dependents covered by any other group health insurance plan including Medicare, whether or not Medicare was elected when eligible to enroll? ☐ Yes ☐ No

If "yes," provide the information requested. If Medicare, copy of the Medicare ID card must be on file with the Administration Office.

Name of Subscriber with Other Coverage _____ Social Security Number _____ Policy or ID Number _____

Name and Address of Other Insurance Group _____ City _____ State _____ Zip Code _____

2. Other Insurance Covers: ☐ Subscriber ☐ Spouse ☐ Children

3. Coverage Includes: ☐ Medical ☐ Dental ☐ Vision

I hereby certify that the above information is true, correct and complete to the best of my knowledge.

Signature (*must be signed by participating employee to be valid*) _____ **Date** _____

Note: Information supplied on this form will not affect your beneficiary designation. To update your beneficiary designation, complete a new Enrollment/Beneficiary Designation Form. Forms are available on the Trust website – www.nwinsulationtrust.com

THIS FORM MUST BE RETURNED BY 02/25/2022

RETURN TO THE ADMINISTRATION OFFICE: NW Insulation, P.O. BOX 34203, SEATTLE, WA 98124-1203

OR Scan and email to: NWInsulationAudit@wpas-inc.com RETAIN A COPY FOR YOUR RECORDS

NW INSULATION WORKERS WELFARE TRUST

Information Verification Form Instructions

- Carefully review the pre-populated Information Verification Form on the reverse side and make sure your and your dependents' information is listed correctly. If corrections are needed, using black or blue ink, please line out the incorrect data and clearly print updated information immediately below the crossed out information. If a spouse or stepchild is listed who is no longer your spouse or stepchild, you must submit a copy of your divorce decree and parenting plan if applicable.
- The definition of Dependent is listed below.
- Please note it is extremely important that the Administration Office have complete information for your dependents, including gender, date of birth, social security number and relationship.
- Due to IRS reporting regulations, the Administration Office MUST have your dependents' social security numbers on file. If XXX-XX-XXXX appears in the social security number column that means the Administration Office has your dependent's SSN. If the there is a blank space in the SSN column you must write in your dependent's complete SSN.
- If you, or any of your dependents, have other group health coverage or Medicare (whether or not enrolled in Medicare when eligible to do so), it is very important that you provide this information on the form. Attach a separate sheet of paper if more room is needed to list additional coverages.
- It is necessary to attach copies of your marriage certificate to verify your spouse's eligibility, and copies of birth certificates (or legal custody/court ordered documents) to verify your child(ren)'s eligibility. Please do not send original documents, a photocopy is sufficient. If the document is two-sided or has multiple pages, ensure you copy all pages and both sides of the paper.
- To avoid future claim denials, a properly completed Information Verification Form must be on file at the Administration Office for you and your dependents.
- Sign, date and return the Information Verification Form to the Administration Office **by 02/25/2022.**
- Keep a copy of this form and all supporting documentation for your records.
- Should you have questions regarding this process please email the Trust at NWInsulationAudit@wpas-inc.com or call 1 (844) 811-6789, option 4.
- Return the form and all necessary documents to the Administration Office in one of the following ways:
    1. Email scanned documents to: NWInsulationAudit@wpas-inc.com– be sure to include "NW Insulation Audit" in the subject line of your email.
    2. Mail using the enclosed Administration Office return envelope.

It is important that you complete this form in its entirety, verifying all eligible dependents (spouse and/or children) by providing documentation verifying their eligibility.

DEFINITION OF DEPENDENT

Your eligible Dependents are:

- The lawful spouse of an Employee or Retired Employee (even if legally separated). The spouse must be legally married to the Employee or Retired Employee as determined under federal law, and must be treated as a spouse under the Internal Revenue Code, including a legally recognized same-sex spouse.
- A child of an Employee or Retired Employee. Children of an Employee or Retired Employee include the following:
    - A natural child, stepchild, adopted child, child "placed for adoption" or "foster child" under the age of 26.
    - A child age 26 or older and unable to engage in any substantial gainful activity by reason of a mental or physical impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, provided the child was an Eligible Dependent and so disabled at the time of reaching the limiting age, and remains dependent upon the Employee or Retired Employee for support and maintenance. Evidence of the child's dependency and incapacity must be filed with the Administration Office within 31 days after attaining the limiting age, and periodically thereafter. The Plan, at its own expense, has the right to designate a Physician to examine the Dependent when and as often as the Plan may reasonably require.