Painters District Council No. 3 Trust Fund

3100 Broadway, Suite 805 Kansas City, Missouri 64111-2413
(816)756-3313 or toll free (866)756-3313

Dear Participant:

Each calendar year it is necessary to update our records for this office. Please provide us with the following information, in lieu of a claim form, for each member. During the year, you may also be required to complete a claim form(s) if a bill is received that appears to be accident related.

Insured's Data
Name _____
Address _____
Social Security # _____Date of Birth_____
Spouse's Data
Name _____
Social Security # _____Date of Birth _____
Spouse's Employer's Name _____
Employer's Address _____Phone # _____
City _____ State _____ Zip Code _____

Does your spouse have other Group Medical Coverage? Yes _____ No _____
If yes, is the coverage type: Single? _____ Family? _____
Medical Insurance Carrier Name _____Phone # _____
Insurance Address _____
Group Contract # _____ Effective Date _____ Term date _____
Does coverage include Dental? _____ Vision? _____

Please provide the complete names & birth dates, etc., for all covered dependents. If a dependent child is employed and/or has other insurance, please include that information. In addition, if you are married, please attach a copy of your marriage certificate. If there is a divorce decree that addresses medical coverage for any dependent children, please supply a copy of that decree.

Dependent's Name	Relationship	DOB	Soc. Sec. #	Employer/Other Insurance

If any of the above information changes during the calendar year, you must advise us immediately. (See back of form for further guidelines.)

We are pleased to be of service to you. Please contact this office if you have any questions.

Please sign below, verifying that the above statements are true to the best of your knowledge and belief. Your signature will also authorize an institution or physician to release information concerning your enrollment, related records and medical records to the fund office, if needed.

_____ _____
Participant's Signature *Date of Signature*

Sincerely,
Benefits Administrator

Additional Dependent Information

Dependent's Name	Relationship	DOB	Soc. Sec. #	Employer/Other Insurance

Any Other Information You Wish to Provide

Life-Changing Events

When you get married, provide the Fund Office with:

- A copy of your marriage certificate
- Your spouse's date of birth
- A copy of your spouse's medical insurance information, if he or she is covered under another plan.

When you add a child, provide the Fund Office with:

- The birth date, effective date of adoption or placement for adoption, or the date of your marriage (for stepchildren)
- A copy of the birth certification, adoption papers, court order, or marriage certification (for stepchildren)
- A copy of your child's other medical insurance information, if he or she is covered under another plan

If you get legally separated or divorced, provide the Fund Office with:

- A copy of your separation or divorce decree
- A copy of any QDRO
- If you have children for whom you do not have custody, a copy of any QMCSO

If your spouse wants to continue coverage, he or she must:

- Contact the Fund Office; and
- Enroll for COBRA Continuation Coverage