NATIONAL ORGANIZATION OF INDUSTRIAL TRADE UNIONS
INSURANCE TRUST FUND

148-06 HILLSIDE AVENUE • JAMAICA, NY 11435 • (718) 291-3434

TO: ALL PLAN PARTICIPANTS OF [INSERT SHOP NAME]

FROM: THE BOARD OF TRUSTEES (THE "TRUSTEES") OF THE NOITU INSURANCE TRUST FUND (THE "FUND")

SUBJECT: RE-ENROLLMENT

DATE:

At the directive of the Trustees of the Fund, the following information concerning you and your eligible dependents is needed to properly administer your benefits in accordance with the terms of the Plan. The information you provide will remain confidential in accordance with the Health Insurance Privacy & Portability Act (HIPAA) and all applicable laws; it will only be used by Fund staff when appropriate or required by law.

Please complete the form on the other side of this page, in its entirety, and return to the Fund office, fully signed and initialed, within 30 days of the date of this letter. In addition, a change of beneficiary card and a self-addressed envelope have been provided for your convenience. Failure to complete these forms may affect future benefit payments.

Thank you in advance for your cooperation. If you have any questions regarding this matter, please contact the Employer Services Department of the Fund office at (718) 291-3434.

Personal Information (Please Print Clearly)

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: ( ) _____ Mobile Phone: ( ) _____

Employer's Name: _____

Email: _____ SS#/Alt. ID# _____

Birth Date: __/__/____ (MM DD YYYY) *Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legally Separated**

* If you are divorced or legally separated, you must enclose a copy of the court order if it has not previously been provided.

MEMBER'S INITIALS _____

Dependent Information (Please Print Clearly)

Spouse Name _____

Name(s) of Children _____

MEMBER'S INITIALS _____

Other Coverage Information (Please Print Clearly)

Are **you** covered under any other health insurance policy, including Medicare, other than your BlueCross Plan through the NOITU Insurance Trust Fund?

Yes ☐ **No** ☐

Insurance Carrier Name _____
Insurance Carrier Address _____
Insurance Carrier Phone # _____
Insurance Policy # _____
Person(s) Covered by Insurance Carrier _____
Effective Date of Coverage _____

Are **any of your Dependents** covered under any other health insurance policy not mentioned above?

Yes ☐ **No** ☐

Insurance Carrier Name _____
Insurance Carrier Address _____
Insurance Carrier Phone # _____
Insurance Policy # _____
Person(s) Covered by Insurance Carrier _____
Effective Date of Coverage _____

MEMBER'S INITIAL'S _____

I understand that the completion of this form in a false, inaccurate or misleading manner is a violation of the rules of the Fund and will result in denial of future claims; collection proceedings or litigation to recover payments made to you or on your behalf; and penalties, which may include suspension or permanent disqualification from the Fund.

_____ _____
MEMBER SIGNATURE **MEMBER PRINT NAME**

_____
DATE