Plumbers and Pipefitters
Local No. 421
Health and Welfare Plan
c/o National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 200 | Pembroke Pines, FL 33028
1 (800) 842-5899 | Fax (954) 266-2079

Welcome to the Plumbers and Pipefitters Local 421 Health and Welfare Plan. Your eligibility for the Plan is determined based upon the contributions your employer reports on your behalf. We encourage you to refer to the Summary Plan Description to learn how the Plan works. The Summary Plan Description describes how you can become eligible for coverage and what is covered by the Plan.

Let's get to know you! You must complete the enclosed enrollment materials. The enrollment materials contain important information about you and your family members, which is needed by NEBA and must be completed even if you do not wish to enroll in the Plan.

If you are declining enrollment for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement of adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the Administrative Manager at (800) 842-5899.

There are several ways to return your enrollment documents.

- Visit https://www.nebainc.com/SendFile.aspx and use the Secure File Upload. If you visit the site on your mobile device, you can use your device camera to upload photos of the documents. Photos must be clear enough to read and you must include a photo of all pages of the form(s).
- Visit https://luxsci.com/perl/public/securesend.pl and register to use the Secure Send Encrypted Email Portal. The portal allows you to create a free email account only for use in sending emails to NEBA in an encrypted fashion.
- Mail them to NEBA at 2010 N.W. 150th Avenue, Suite 200 | Pembroke Pines, FL 33028.
- Fax them to NEBA at (954) 266-2079.

Service

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Enrollment Form

1. First, tell us about yourself.

Please complete all boxes.

First Name		Middle Initial		Last Name	
Gender	☐ Male ☐ Female	Birthdate	/ /	SSN	
Address					
City, State Zip			Marital Status		

2. If we need to get in touch with you, what do you prefer?

Please mark your preferred method.

☐	Call me	Home: ( ) -	Cell: ( ) -	Work: ( ) -
☐	Email me	Email Address:	☐ Mail to me at the address listed above	

3. Do you want to enroll for coverage under the Plan?

Choose one of the options below.

☐	Option	Statement
☐	YES, enroll me for Employee Only coverage.	I request coverage under the Plumbers and Pipefitters Local 421 H&W Plan. If I am enrolling dependents, I understand that I will be required to submit supporting documents, which demonstrate that my dependents are eligible for coverage, such as my children's birth certificate or my marriage certificate. Signature: ______________________ Date: _________
☐	YES, enroll me & my eligible dependents in the Plan.	
☐	NO, do not enroll me. I have other health plan coverage.	I understand that by declining coverage, I am waiving all benefits to which I am entitled. Under the Affordable Care Act, if I do not have health insurance, I may be subject to a fee called the individual shared responsibility payment. Signature: ______________________ Date: _________
☐	NO, do not enroll me. I do not have other plan coverage.	

Service

4. Which doctor in the CIGNA OAP Network will provide your primary care?

If you don't currently have an in network Primary Care Physician (PCP), please call Cigna CareAllies at 1-800-768-4695. Cigna CareAllies can help you find a doctor in your area that participates in the Cigna OAP Provider Network. You are not required to name a PCP, but you are encouraged to do so. It's important to establish a relationship with a PCP before you get sick! If you don't, it can be difficult to get an appointment when you need one.

Physician Name:	**Physician Address:**
Physician Phone Number:	

5. Are you enrolling dependents? If so, please complete the section below.

To enroll your dependents you will need to provide copies of their social security cards (if available), birth certificates (required for children), and a marriage certificate (required for spouses and stepchildren). Other documents may be required and could be requested by NEBA. To add dependents, please fill out their information below and submit the required documents to NEBA via fax, secure email, website upload, or mail within 15 days. Dependents will not be enrolled in the Plan if the documentation is not submitted timely.

The term "Dependent" is defined in the Plan Document as a spouse, natural child, adopted child, stepchild, foster child, and/or any child for whom there is a Qualified Medical Child Support Order, which states that health care coverage must be maintained by the Covered Employee. Dependent children are eligible only through the end of the month in which they attain age 26.

Complete the following section if you are enrolling dependents.			
Dependent 1:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**		**Phone:**
Dependent 2:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**		**Phone:**
Dependent 3:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**		**Phone:**
Dependent 4:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**		**Phone:**
Dependent 5:			
Full Name:	**Relationship:**	**SSN:**	**DOB: / /**
Primary Care Physician:	**Address:**		**Phone:**

Please contact NEBA if you wish to add more than five dependents.

6. Last, name your beneficiary.

In the event of your death, your named beneficiary will receive the Employee Death and AD&D Benefits for which you qualify. If you wish to list more than one beneficiary, please tell us what percentage of your benefits you wish to assign to each person. The total of the percentages must equal 100%.

	Beneficiary 1	%	Beneficiary 2	%
Name:		%		%
SSN:				
Address:				
City, State & Zip:				
Date of Birth:				
Relationship:				
Telephone Number:				

Contingent Beneficiary

(If your Primary Beneficiaries are deceased)

	Contingent Beneficiary 1	%	Contingent Beneficiary 2	%
Name:		%		%
SSN:				
Address:				
City, State & Zip:				
Date Of Birth:				
Relationship:				
Telephone Number:				

***Please contact the Fund Office if you wish to add more than two beneficiaries or contingent beneficiaries.**

By signing this Enrollment Application, I acknowledge that this election will remain in effect for subsequent years, unless I change or revoke it by completion and submission of an appropriate form provided by the Plan Administrator during a subsequent annual or special enrollment period.

That's it! *Thank you for completing your enrollment form.*