CHARLES TOWN WELFARE BENEFIT TRUST
OWNERS/TRAINER FORM
MEMBERSHIP INFORMATION
2017

NAME_____
(Print) LAST FIRST MIDDLE DATE OF BIRTH

STABLE NAME_____

ADDRESS_____ Spouse_____
If Different

_____

PHONE #_____ CELL #_____

TYPE OF LICENSE _____ SS# or TIN#_____

PARTNERSHIP NAMES AND PERCENTAGE _____

STABLED AT_____

LIST EMPLOYEES

NAME_____ LENGTH OF EMPLOYMENT

NAME_____ LENGTH OF EMPLOYMENT

DEPENDENTS

SPOUSE_____ DATE OF BIRTH_____

NAME OF CHILDREN_____ AGE ___

_____ AGE ___

STUDENT'S _____ SCHOOL _____

INSURANCE
WORKERS COMPENSATION_____
BLUE CROSS_____
OTHER_____
These bills are not workers compensation related.
The undersigned hereby states that all information given on this application is true.
Subject to forfeiture of benefits if found to be falsified
All benevolence is subject to availability of funds

_____ _____
SIGNATURE DATE

CHARLES TOWN WELFARE BENEFIT TRUST
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All Benevolence is subject to availability of funds ***Form Revised 1/1/17***

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize Charles Town HBPA WELFARE BENEFIT TRUST to obtain individually identifiable health information from health providers (including) pharmacists, who have rendered services to me and consent to those health care providers disclosure of such information to the trust for purposes of claims processing, payment and/or reimbursement.

I hereby authorize Charles Town HBPA WELFARE BENEFIT TRUST to obtain individual information pertaining to the status of eligibility rendered to my dependants.

I understand that this authorization will expire on **12/31/2017**

I understand that I may revoke this authorization at any time by notifying the Trust in writing. The revocation will have no affect on actions taken by the Trust prior to receipt of the revocation.

_____ _____

SIGNATURE **DATE**

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION