

**CHARLES TOWN WELFARE BENEFIT TRUST
OWNER/TRAINER FORM
MEMBERSHIP INFORMATION**

Applications will be processed on or about the 1st & 15th of each month

NAME _____
(Print) LAST FIRST MIDDLE DATE OF BIRTH

ADDRESS _____ Spouse: _____
If Different _____

PHONE # _____ CELL # _____

TYPE OF LICENSE _____ SS# or TIN# _____

Spouse SS# or TIN# _____

LIST EMPLOYEES

NAME _____ LENGTH OF EMPLOYMENT _____

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

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AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize **Charles Town WELFARE BENEFIT TRUST** to obtain individually identifiable health information from health providers (including) pharmacist, 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 reimbursements.

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 12/31/09

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

Signature

Date

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION