**INSTRUCTIONS:** 

Complete EACH section front and back. SIGN and DATE. Use INK. PRINT. Data provided will replace all information on file with the Trust Office. For questions, call **1** (800) 458-3053.

MAIL TO: Washington Teamsters Welfare Trust 2323 Eastlake Avenue East Seattle WA 98102-3393

WASHINGTON

TEAMSTERS

WELFARE TRUST

**NOTE:** Once enrolled you may register at <u>www.nwadmin.com</u> and make future changes to your participant data on-line in lieu of resubmitting this form ADMINISTRATIVE USE ONLY DATE: \_\_\_\_\_

INITIALS:

PARTICIPANT DATA						
LAST NAME	FIRST NAME	IAME			MIDDLE INITIAL	
			1			
SOCIAL SECURITY NUMBER			DATE OF BIRTH			
MAILING ADDRESS	CITY, STATE, ZIP		PHONE NUMBER			
		Home		Cell		
MARITAL STATUS						
SINGLE MARRIED Date of Marriage:		DIVORCED Date of Divorce:			Widowed	
EMPLOYER (COMPANY NAME)		DATE OF HIRE		LOCAL UNIO	N NO.	
EMAIL ADDRESS		I	1			

## ELIGIBLE DEPENDENT DATA

Check here if you have no spouse or eligible dependents as described below.

If you do have eligible dependents, complete this section and list ALL your eligible dependents each time you submit this form. Eligible dependents include the following (see plan book for complete details):

1. Your spouse or domestic partner.

NOTES: A. You may enroll a domestic partner **only if** your employer provides domestic partner coverage. If enrolling in the Trust Plan and have not previously enrolled your domestic partner, you must also obtain and attach the Trust's Affidavit of Domestic Partnership and required proof of domestic partnership (refer to affidavit for list of acceptable proof); B. You may elect to not list a spouse only due to death, divorce, or legal separation or if your spouse consents to not being covered (documentation may be required).

- 2. Your natural or adopted children and step-children under 26 years of age or incapable of self-support because of mental or physical incapacities.
- 3. Your unmarried grandchildren, children for whom you have been appointed guardian by the court, and children of your domestic partner *if your employer provides domestic partner coverage*, who either (a) are under 19 years of age, live with you, and are dependent on **you** for support and maintenance, or (b) meet the conditions of (a) but are either 19 through 25 years of age and also full-time students in an accredited educational institution, or incapable of self-support because of mental or physical incapacities.

**NOTE:** When enrolling a NEW dependent only, the Plan requires all Participants to submit documentation to verify dependency status as described above. Claims submitted on behalf of dependents that have not been verified <u>will not be paid</u> until the required documentation has been submitted. *If you have previously verified your dependent's eligibility* you do not need to submit documentation again. Contact the Trust's administrative office if you have guestions regarding what documentation is required. Such documentation may include, but is not limited to:

	Spouse – Marriage Certificate	Child -	– Birth Certificate,	/Proof of Adoptic	on Ward – Guardianship P			rs		
If adding a NEW dependent, please submit copies of the required documentation for each dependent along with this form.										
Please read #2 and #3 above before listing children. LAST NAME FIRST INITIAL		DATE OF BIRTH	RELATION	SOCIAL SECURITY NO.	GENDER		DOES CHILD LIVE WITH YOU?			
							MALE	FEMALE	YES	NO

IF YOU HAVE ADDITIONAL DEPENDENTS PLEASE ATTACH A SEPARATE SHEET OF PAPER PLEASE COMPLETE REVERSE SIDE. PARTICIPANT MUST SIGN AND DATE FORM.

## PARTICIPANT DATA FORM – Side 2

If any dependent(s) adde to coverage is covered under another healthcare plan and the natural parents are divorced or separated, Washington         Name of PARENT WIN LUSTOW (IP PARENTS HAVE DOWN CUSTOV), INDICATE HARE IT       INTICATE OF OTHER PARENT         If divorced, did a court establish financial responsibility for the child(ren's health care?       INTICATE ADDR         If, yes, the responsible person(s) are:       INTICATE ADDR       INTICATE, ZP       PHORE NUMBER         THE TADRESS OR PO BOX       INTICATE, ZP       PHORE NUMBER         OTHER TWINK LOSTOW (IP PARENTS HAVE DOWN CUSTOV), INDICATE HARE)         INTICATE CARE         INTICATE CARE         THE FORM MILL BE RETURNED IF THIS SECTION IS NOT COMPLETED IN FULL WHICH WILL DELAY THE ENROLLMENT PROCESS.         If you or dyou dopendents have on other insurance.       Policy No. 2       Policy No. 3         If you or dyou dopendents have on other insurance.       Policy No. 1       Policy No. 2       Policy No. 3         Type of healthcare Down ag group retiree medical plan, including MEDICARE) or this Trust, please complete this sector.       Quel pendent       Quel pendent         Name of Insured Person       Immedicat       Quel pendent       Quel pendent       Quel pendent         SN of Insured Person       Immedicat       Quel pendent       Quel pendent       Quel pendent         SN of Insured Person	DEPENDENT CHILDREN OF DIVORCED OR SEP	PARATED PARENTS					
NAME OF PARENT WITH CUSTODY (IF PARENTS HAVE JOINT CUSTODY, INDICATE here       INTITE OF OF OTHER PARENT         if divorced, did a court establish financial responsibility for the child(ren)'s health care?       YES       NO         If yes, the responsibile person(s) are:       STREET ADDRESS OR PO BOX       CITY, STATE, ZIP       PHORE NUMBER         NAME       STREET ADDRESS OR PO BOX       CITY, STATE, ZIP       PHORE NUMBER         OTHER INSURANCE DATA         THIS FORM WILL BE RETURNED IF THIS SECTION IS NOT COMPLETED IN FULL, WHICH WILL DELAY THE ENROLLMENT PROCESS.         if you or any of your dependents have on bad coverage with any other healthcare plan in the last 12 months (coverage through an insurance company, a self-insured plan, a group retiree medical plan, including MEDICARE) or this Trust, please complete this section.         Yup of Healthcare Coverage       Medical       Dental       Medical       Dental         (check all that apply)       Vision       Other       Vision       Other       Vision         Name of Insured Person       SSN of Insured Person       Insured Selationship to Dependent(s)       Insured       Insured Person       Insured Person         Name of Insured Person       Insured Coverage       Insured Person       Insured Person       Insured Person       Insured Person         Name of Insured Person'S Employer       Insured Coverage       Insured Person'S Employer				or separated, Washington			
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	Effective Date of Coverage						
	Termination Date of Coverage, if not Active						

## FAILURE TO FILE OR UPDATE YOUR PARTICIPANT DATA OR SUBMIT THE REQUIRED DEPENDENT VERIFICATION DOCUMENTATION WITH THE ADMINISTRATIVE OFFICE MAY DELAY THE PROCESSING OF YOUR CLAIMS

It is a crime to knowingly provide false, incomplete, or misleading information to the Trust Administrative Office for the purpose of defrauding the Trust. Penalties include imprisonment, repayment of all claims paid inappropriately, fines, and denial of insurance benefits. With my signature, I hereby certify that the information provided on this Participant Data Form is true and correct and I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to the Washington Teamsters Welfare Trust or its designated agent.



DATE SIGNED

PARTICIPANT'S SIGNATURE

WASHINGTON

TEAMSTERS