NORTHWEST LABORERS-EMPLOYERS HEALTH & SECURITY TRUST

11724 NE 195th Street, Suite 300 ◆ Bothell, WA 98011
206.282.3600 or 800.826.2102 FAX 206.217.0806
nwlelg@zenith-american.com

ENROLLMENT FORM

INSTRUCTIONS	Please read and complete all information on this form

The Enrollment Form must be completed in order to enroll you and your dependents, if applicable, for healthcare coverage. Be sure to complete ALL of the information requested on this Enrollment Form.

Completion of this Enrollment/Change Form does not constitute a guarantee of benefits. Actual benefits are based on eligibility and Plan provisions in effect at the time of service. Please refer to your Summary Plan Description for eligibility rules and a complete list of benefits

Section 1 **TYPE OF CHANGE – if one or more changes, check all that apply and provide the required documentation (**Dependents will NOT be covered until the required documentation is received.)

☐ Add children from birth to 26
Copy of the State Certified Birth Certificate Decree/ Court appointed/adoption papers

☐ Add spouse
Copy of the State issued Certificate of Marriage

☐ Delete spouse or dependent(s)
Copy of the State issued Divorce or Legal Separation papers

☐ Change of address ☐ Change Dental Plan ☐ Name change (legal proof required) ☐ Beneficiary Change

Section 2 **DENTAL PLAN ELECTION Please check the appropriate box:**

☐ I elect Dental Plan A. I understand that my family must receive all care at a Willamette Dental Center.

☐ I elect Dental Plan B – a scheduled benefit plan-administered by Delta Dental of Washington.

Section 3 **PARTICIPANT / EMPLOYEE INFORMATION**

Last Name	First Name	MI	Gender	Social Security # (required)	Union Local
				__ __ __ - __ __ - __ __ __ __	

Participant Mailing Address (Street or PO Box) City State Zip Code

Date of Birth	Current Marital Status	Date of Marriage / Divorce
	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legal separation	

Cell Phone Number	Home Phone Number	E-mail Address

Section 4 **DEPENDENT(S) TO ENROLL – SPOUSE/CHILDREN (List additional dependents on a separate sheet)**

Please list all dependents that you wish to be covered. Eligible dependents that may be covered under the Plan are your spouse and children as defined by the Plan. Provide the Social Security Number of each dependent you enroll. Federal regulations require health plans to report the names and Social Security Numbers of every covered individual to the IRS. **Please note the Trust requires the following documentation: Children - Copy of the State Certified Birth Certificate Decree/ Court appointed/adoption papers. Spouse - Copy of the State issued Certificate of Marriage. (Dependents will NOT be covered until the required documentation is received.)**

Last Name	First Name	MI	Relationship	Gender	Date of Birth	Social Security # (required)
						__ __ __ - __ __ - __ __ __ __
						__ __ __ - __ __ - __ __ __ __
						__ __ __ - __ __ - __ __ __ __
						__ __ __ - __ __ - __ __ __ __
						__ __ __ - __ __ - __ __ __ __

Do any of your dependents have other health care coverage? ☐ No ☐ Yes

If yes, list dependent (s) who has other insurance_____

Name of other Insurance Company _____ Effective Date _____

COMPLETION OF ADDITIONAL SECTIONS AND SIGNATURE(S) REQUIRED ON OTHER SIDE

Section 5 DELETE THE FOLLOWING FAMILY MEMBERS

List ALL family members you wish to remove from the Plan and include the reason for removal. Please attach supporting documentation i.e. divorce decree, death certificate.

Last Name	First Name	Reason	Date of Birth	Effective Date	Social Security #
					__ __ __ - __ __ - __ __ __ __
					__ __ __ - __ __ - __ __ __ __
					__ __ __ - __ __ - __ __ __ __

Section 6 MEDICARE COVERAGE FOR YOU OR YOUR DEPENDENT(S) Attach additional page if needed.

You — Covered by Medicare?

☐ No ☐ Yes (indicate coverage types) HICN Number: _____

☐ Medicare Part A (Hospital only) ☐ Medicare Parts A and B

Your Spouse — Covered by Medicare?

☐ No ☐ Yes (indicate coverage types) HICN Number: _____

☐ Medicare Part A (Hospital only) ☐ Medicare Parts A and B

Your Dependent(s) Child(ren) — Covered by Medicare?

☐ No ☐ Yes (indicate coverage types) HICN Number: _____

☐ Medicare Part A (Hospital only) ☐ Medicare Parts A and B

Section 7 BENEFICIARY OF DEATH BENEFIT (LIFE INSURANCE) (List additional beneficiaries on a separate sheet)

This is to certify that I hereby revoke all former beneficiary designations, if any, and name the following as beneficiary for any death benefit payable under the NORTHWEST LABORERS-EMPLOYERS HEALTH & SECURITY TRUST. If you are married and the beneficiary you choose is not your spouse, your spouse must consent to the designation by signing below*. A designation of your spouse will automatically revoke at the time your marriage is dissolved. You must complete a new beneficiary designation following dissolution of marriage, even if you intend to re-designate your former spouse. To add more Beneficiaries, please attach additional page. Total of % amounts must equal 100%.

Primary Beneficiary's Last Name	First Name	Initial	Relationship	Social Security # or Tax ID #	% of benefit
				__ __ __ - __ __ - __ __ __ __	

Mailing Address (Street or PO Box) City State Zip Code

Secondary Beneficiary's Last Name	First Name	Initial	Relationship	Social Security # or Tax ID #	% of benefit
				__ __ __ - __ __ - __ __ __ __	

Mailing Address (Street or PO Box) City State Zip Code

SPOUSE'S CONSENT OF LIFE INSURANCE BENEFICIARY: By my signature below, I certify that I am legally married to the participant and authorize the life insurance beneficiary designation.

X ***Spouse Signature*** **Date:**

Section 8 PARTICIPANT SIGNATURE Required (PLEASE READ AND SIGN BELOW)

I UNDERSTAND THAT THE Trust Fund is relying on my answers on this form. I declare, under penalty of perjury under the laws of the State of Washington, that the answers given to all questions on this form are true and accurate. I understand that if I knowingly and with intent to defraud the Trust Fund, conceal or provide any materially false information, I may be subject to civil or criminal liability.

I hereby certify that the foregoing statements, including any accompanying statements and/or documents, are true, correct and complete to the best of my knowledge, and hereby further authorize my Provider of service to release any medical or other information necessary to process claims. A photocopy will be considered the same as the original.

X ***Participant's Signature*** **Date:**

Are you a Retiree? ☐ No ☐ Yes