

NW PLUMBERS & PIPEFITTERS HEALTH FUND

www.nwplumberstrust.com

PLEASE PRINT

ENROLLMENT FORM

F31

IMPORTANT: Please complete this form in its entirety, listing all eligible dependents (spouse and/or children) and current beneficiary. This form will replace any other enrollment/beneficiary form on file at the Administration Office.

<input type="checkbox"/> New Member	<input type="checkbox"/> Name Change _____ <small style="margin-left: 100px;">previous name</small>	<input type="checkbox"/> Beneficiary Change	<input type="checkbox"/> Address Change
<input type="checkbox"/> Add Dependents	<input type="checkbox"/> Remove Dependents		

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX	BIRTHDATE (Mo/Day/Year)	RELATIONSHIP to SUBSCRIBER	Check if Step, Foster or Adopted Child
Member				Self	
Spouse				Date of Marriage	
Eligible Dependents*					

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

Phone Number	E-mail Address
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*The Plan may require documentation for all dependents: Spouse – Marriage Certificate; Child(ren) – birth certificate, legal guardianship, and if adult child is married, a marriage certificate.

1. Are you, your spouse, or other dependents covered by any other group health insurance plan including Medicare?
 Yes No If "yes," please provide the information requested. If Medicare, copy of Medicare ID card must be on file with the Administration Office:

Name of Subscriber with Other Coverage	Soc. Sec. No.	Policy or I.D. Number
Name, address and phone # of other Insurance Company	City	State Zip Phone#

2. Insurance covers: Subscriber Spouse Children 3. Other coverage includes: Medical Dental Vision

4. Does spouse's employer offer group health insurance? Yes No Did spouse decline that coverage? Yes No

Beneficiary Designation – If you do not designate a beneficiary, your death benefits will be paid in the order of preference outlined in your plan booklet. If you wish to change your beneficiary designation, please complete a new Enrollment Form.

Health & Welfare _____ Relationship _____
Name

Address _____ Soc. Sec. No. _____

Vacation _____ Relationship _____
Name

Address _____ Soc. Sec. No. _____

I hereby certify that the above information is true, correct, and complete to the best of my knowledge and supersedes any beneficiary designation signed prior to the date shown below.

Date _____

 Signature (must be signed by participating member)

RETURN A COPY TO ADMINISTRATION OFFICE: P.O. BOX 34203 • SEATTLE, WA 98124-1203 OR Scan and email to: enrollment@wpas-inc.com OR
 Fax to: (206) 505-9727 RETAIN A COPY FOR YOUR RECORDS

NOTICE

Please be advised that this form **MUST** be signed by the participating Member for beneficiary designations to be valid.

DEFINITION OF DEPENDENT ELIGIBILITY

A dependent is:

- An eligible Employee's legal spouse (husband or wife).
- All of the eligible Employee's dependent children, including any foster children, step-children, or adopted children between the date of birth and up to 26 years of age.
- "Foster children" shall mean any child for which an Employee becomes legally obligated by a court of competent jurisdiction to perform the duties of a parent to the child of another by rearing the child as his own.
- Dependent children who are primarily dependent on the employee because of physical or mental disability may be continued as eligible dependents provided the dependent was covered immediately prior to their 26th birthday and the incapacity occurred prior to their 26th birthday. Proof of such incapacity must be provided to the Trust.