NORTHWEST PLUMBING AND PIPEFITTING INDUSTRY HEALTH, WELFARE AND VACATION TRUST

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.

☐ New Member ☐ Name Change_____ ☐ Beneficiary Change ☐ Address Change
previous name

☐ Add Dependents ☐ 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**

*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 WHITE 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 YELLOW 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.