

WASHINGTON TEAMSTERS WELFARE TRUST

Participant Data Form

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

NOTE: Once enrolled you may register at www.nwadmin.com and make future changes to your participant data on-line in lieu of resubmitting this form

ADMINISTRATIVE USE ONLY Date: _____ Initials: _____
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PARTICIPANT DATA

_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female	_____
Social Security Number			Date of Birth
_____	_____	_____	_____
Participant Last Name	First Name		Middle Initial
_____			_____
Mailing Address			<input type="checkbox"/> Single
			<input type="checkbox"/> Married – date: _____
			<input type="checkbox"/> Divorced – date: _____
_____	_____	_____	
City	State	Zip Code	
_____	_____	_____	_____
Employer (Company Name)	Date of Hire	Union Local No.	Home Phone Number

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.
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.
Note: Employees participating in a grandfathered Medical Plan through the Trust (Plans JC28XL or WT100) may not cover a child ages 19-25 under any of their Trust coverage until July 1, 2014 if the child has access to other employer sponsored health coverage through the child's own employment. If you do not know which plan your medical coverage is under, please refer to your collective bargaining agreement, or contact the Trust Office, your employer, or local union.
3. Your domestic partner *if your employer provides domestic partner coverage*. Attach the Washington Teamsters Welfare Trust's Affidavit of Domestic Partnership and required proof of domestic partnership (refer to affidavit for list of acceptable proof).
4. 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. **Please attach proof of dependency or guardianship.**

Proof may be requested if determined necessary; i.e. birth certificate, guardianship papers, proof of incapacity, marriage certificate, divorce papers, etc.

<i>Please read #2 and #4 above before listing children.</i>								
Last Name	First	Initial	Date of Birth	Relation	Social Security No.	Gender	Does child live with you?	
					- -	M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
					- -	M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
					- -	M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
					- -	M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
					- -	M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
					- -	M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
					- -	M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
					- -	M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
					- -	M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
					- -	M <input type="checkbox"/> F <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	

PLEASE COMPLETE REVERSE SIDE. PARTICIPANT MUST SIGN AND DATE FORM

DEPENDENT CHILDREN OF DIVORCED OR SEPARATED PARENTS

If any dependent(s) added to coverage is covered under another health care plan and the natural parents are divorced or separated, Washington State regulations require that the information requested below be completed in full.

Name of Parent with Custody (if parents have dual custody, indicate)

Birth Date of Other Parent

If divorced, did a court establish financial responsibility for the child(ren)'s health care? No Yes, the responsible person(s) are:

Name

Street Address or PO Box

City

State

Zip Code

Phone Number

OTHER INSURANCE DATA

THIS FORM WILL BE RETURNED IF THIS SECTION IS NOT **COMPLETED IN FULL**, WHICH WILL DELAY THE ENROLLMENT PROCESS.

Check here if you or your dependents have no other insurance.

If you or any of your dependents have coverage with any other health care plan (coverage through an insurance company, a self-insured plan, a group retiree medical plan, including MEDICARE) or this Trust, please complete this section.

	Policy No. 1	Policy No. 2	Policy No. 3
Type of Healthcare Coverage	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other
Name of Insured Person			
SSN of Insured Person			
Name(s) of Dependent(s) covered under this insurance			
Insured's Relationship to Dependent(s)			
Name of Insured Person's Employer			
Name of Insurance Company			
Insurance Co. Street Address or PO Box			
City			
State, Zip Code			
Insurance Company Phone No.			
Group or Policy Number			
Effective Date of Coverage			

FAILURE TO FILE OR UPDATE YOUR PARTICIPANT DATA 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.

If I participate in a grandfathered Medical Plan through the Trust (Plan JC28XL or WT100), I also certify that any child ages 19-25 listed on the front of this form does not have access to other employer sponsored health coverage through the child's own employment.

x

PARTICIPANT'S SIGNATURE

DATE SIGNED