

WASHINGTON TEAMSTERS WELFARE TRUST

Participant Data Form

INSTRUCTIONS:

- Use INK and PRINT all information.
- If this is your first filing, participant must complete the form IN FULL, SIGN and DATE.
- If you are updating information only, list only your name, Social Security Number, the changed data, SIGN, and DATE form

RETURN COMPLETED FORM TO:
 Washington Teamsters Welfare Trust
 2323 Eastlake Avenue East
 Seattle, WA 98102-3393
 (206) 726-3277 or 1-800-458-3053

PARTICIPANT DATA

_____ Male Female
 Social Security Number _____ Date of Birth _____

 Participant Last Name First Name Middle Initial

 Address (Mailing)

 City State Zip Code

 Employer (Company Name) Date of Hire Union Local No. Home Phone Number

Single
 Married _____ Date Married
 Divorced _____ Date Divorced

ELIGIBLE DEPENDENT DATA

LIST ELIGIBLE DEPENDENTS – Your eligible dependents (see plan book for more details) include:

1. Your spouse.
2. Your unmarried children that are either (a) less than 19 years old **or** (b) age 19 but under 26 years **if attending an accredited educational institution as a full-time student** **or** (c) incapable of self-support because of mental or physical incapacities.
3. Your step-children, grandchildren, and children for whom you have been appointed legal guardian by the court **if they meet the criteria in number 2 above, reside with you, and are dependent upon you for support and maintenance.**
4. **If** your employer has domestic partner coverage, your domestic partner and any of his/her unmarried children that are dependent on **you** for support and maintenance, **if** child is either (a) under 19 years old and residing with you and your partner **or** (b) at least 19 but under 26 and enrolled full-time in an accredited educational institution **or** (c) disabled and physically or mentally incapable of self-support. Attach Affidavit of Domestic Partnership.

Proof of dependent eligibility may be requested; i.e. birth certificate, legal guardianship letters, proof of incapacity, marriage certificate, divorce papers, or student letters bearing school seal. Proof of domestic partnership is also required if your employer has domestic partner coverage.

Last Name	First	Middle Initial	Date of Birth	Relationship to Participant	Social Security No.	Sex	Does dependent reside with you? If no, complete next section.
					- -	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
					- -	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
					- -	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
					- -	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
					- -	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Use bottom of reverse side to name additional dependents.

IF DEPENDENT(S) DO NOT RESIDE WITH PARTICIPANT, COMPLETE ABOVE AND BELOW

Dependent(s) Name	Participant's Relation to Dependent(s)	Name and mailing address of the person with whom the dependent(s) resides (please print)
		Name _____ Street or PO Box _____ City _____ State _____ Zip _____
		Name _____ Street or PO Box _____ City _____ State _____ Zip _____
		Name _____ Street or PO Box _____ City _____ State _____ Zip _____

PLEASE COMPLETE REVERSE SIDE. PARTICIPANT MUST SIGN AND DATE FORM

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 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.

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

Type of Coverage Medical Dental Vision Other, i.e., Rx, Chiropractic, Mental Health

Name of Dependents covered under this other insurance _____ Name of Insurance Company _____ Name of Insured Person _____
 Insurance Company Address _____ SSN of Insured Person _____
 Insurance Company Phone No. _____ City, State, Zip Code _____ Relationship to Dependent _____
 Effective Date of Coverage _____ Group or Policy Number _____

Type of Coverage Medical Dental Vision Other, i.e., Rx, Chiropractic, Mental Health

Name of Dependents covered under this other insurance _____ Name of Insurance Company _____ Name of Insured Person _____
 Insurance Company Address _____ SSN of Insured Person _____
 Insurance Company Phone No. _____ City, State, Zip Code _____ Relationship to Dependent _____
 Effective Date of Coverage _____ Group or Policy Number _____

Type of Coverage Medical Dental Vision Other, i.e., Rx, Chiropractic, Mental Health

Name of Dependents covered under this other insurance _____ Name of Insurance Company _____ Name of Insured Person _____
 Insurance Company Address _____ SSN of Insured Person _____
 Insurance Company Phone No. _____ City, State, Zip Code _____ Relationship to Dependent _____
 Effective Date of Coverage _____ Group or Policy Number _____

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 the court establish financial responsibility for the child(ren)'s health care? No Yes, if yes, please specify name and address of the person with responsibility: _____

Name Address

City State Zip Code Phone Number

ADDITIONAL DEPENDENT DATA

Last	First	Middle Initial	Date of Birth	Relationship to Participant	Social Security No.	Sex	Does dependent reside with you? If no, complete front section
					- -	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
					- -	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
					- -	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAILURE TO FILE OR UPDATE YOUR PARTICIPANT DATA FORM WITH THE ADMINISTRATIVE OFFICE MAY DELAY THE PROCESSING OF YOUR CLAIMS

With my signature, I hereby certify that the information provided in this Participant Data Form is true and correct. 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.

ADMINISTRATIVE USE ONLY

× _____
 PARTICIPANT'S SIGNATURE DATE SIGNED

Date: _____
 Initials: _____