NORTHWEST AND ALASKA IRONWORKERS TRUST FUNDS

PLEASE PRINT **ENROLLMENT FORM/BENEFICIARY DESIGNATION FORM** **F15**

Local Union Number _____ ☐ **New Member** ☐ **Address Change** ☐ **Change/Add Dependent(s)** ☐ **Change Beneficiary** ☐ **Open Enrollment**
If you are adding a dependent you must provide a copy of the birth, marriage certificate or other proof of dependency. If removing a spouse, provide a copy of your divorce decree or death certificate. **Please complete this form in its entirety, listing all dependents you wish to cover, it will replace any form currently on file with the Administration Office.**

CHOICE OF MEDICAL PLAN: New Employees who meet the eligibility requirements for coverage will be automatically enrolled in the Comprehensive PPO Medical Benefits Plan. Annually at Open Enrollment, if you reside in SW Washington or Oregon, you may instead elect the Kaiser Foundation Health Plan of the Northwest, or move from the Kaiser Foundation Health Plan of the Northwest to the Comprehensive PPO Plan. **I elect the following Medical Plan:**

☐ Comprehensive Premera PPO Medical Plan – Note: This plan also includes Prescription Drug, Vision, Life/AD&D, and Disability Benefits

☐ Kaiser Foundation Health Plan of the Northwest Medical, Rx and Vision Coverage – Note: Life/AD&D, and Disability Benefits are provided by the Ironworkers Plan

I elect the following Dental Plan: ☐ Self-Funded Dental Plan ☐ Kaiser Dental HMO Plan (you must live within the service area)

NAME (Last, First, Middle Initial)	**SOCIAL SECURITY NUMBER**	**SEX**	**BIRTHDATE** (Mo/Day/Year)	**RELATIONSHIP to MEMBER**	**Check if Step, Foster or Adopted Child**
Member				**Self**	
Mailing Address (Street or PO Box, City, State, Zip Code)					
Phone Number			**E-mail Address**		
Spouse				**Date of Marriage**	
Eligible Dependents (see back for definition)					☐
					☐
					☐
					☐

1. Are you, your spouse, or other dependents covered by any other group medical, dental or vision plan including Medicare? ☐ Yes ☐ No If "yes", please provide the information below. If covered by Medicare, a copy of your Medicare ID card must be on file with the Administration Office. List additional coverages on the reverse side of this form.

_____
Name of Person with Other Coverage Soc. Sec. Number Policy or I.D. Number

_____
Name and Address of other Insurance Company City State Zip

2. Insurance Covers: ☐ Subscriber ☐ Spouse ☐ Children 3. Coverage includes: ☐ Medical ☐ Dental ☐ Vision

BENEFICIARY DESIGNATION: You may name anyone as your Beneficiary to receive benefits from the Trust Funds. However, if you have been legally married for one year as of your date of death, your surviving spouse will receive any Retirement and/or Annuity benefits payable. In community property states your surviving spouse is also entitled to any community property interest in the Vacation and/or Health and Security benefits. **You must indicate your named beneficiary below even if you are married and intend for your benefits to be paid to your spouse.**

ALASKA RETIREMENT PLAN – Death Benefit

Beneficiary Name: _____
Last *First*

Beneficiary Address: _____
Street or PO Box

_____
City, State, Zip

NORTHWEST RETIREMENT PLAN – Death Benefit

Beneficiary Name: _____
Last *First*

Beneficiary Address: _____
Street or PO Box

_____
City, State, Zip

NORTHWEST/ALASKA ANNUITY PLAN – Death Benefit

Beneficiary Name: _____
Last *First*

Beneficiary Address: _____
Street or PO Box

_____
City, State, Zip

HEALTH & SECURITY – Life Insurance/PTO

Beneficiary Name: _____
Last *First*

Beneficiary Address: _____
Street or PO Box

_____
City, State, Zip

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. *It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.*

_____ **Date: _____**
Participant Signature *(must be signed by participating member)*

RETURN WHITE COPY TO THE 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

151I-11/2019 **RETAIN YELLOW COPY FOR YOUR RECORDS**

HEALTH AND SECURITY PLAN
DEFINITION OF ELIGIBLE DEPENDENT

Your eligible dependents are covered whenever you are covered. Eligible dependents include your:

- Lawful Spouse (including your legally separated spouse).
- Natural child, stepchild, adopted child, child placed for adoption or foster child under the age of 26.

Refer to your Plan booklet for more detailed dependent eligibility information.

List additional separate coverage below:

Name of Person with Other Coverage | Soc. Sec. No. | Policy or I.D. Number

Name and Address of other Insurance Company | City | State | Zip

Insurance covers: ☐ Subscriber ☐ Spouse ☐ Children | 3. Coverage includes: ☐ Medical ☐ Dental ☐ Vision

Name of Person with Other Coverage | Soc. Sec. No. | Policy or I.D. Number

Name and Address of other Insurance Company | City | State | Zip

Insurance covers: ☐ Subscriber ☐ Spouse ☐ Children | 3. Coverage includes: ☐ Medical ☐ Dental ☐ Vision

Please note, in order for the Trust's dental and vision plans to be considered excepted benefits for the purposes of federal law, the Trust is required to provide you with the option of opting out of the Trust's dental and vision benefit plans. Electing to opt out of the Trust's dental and vision plans will not change your hour bank back-out factor or the hours/contributions required to obtain Trust coverage. If you nonetheless want to opt out of the Trust's dental and vision plans, please send a request in writing to the Trust Administration Office at the address provided on the front side of this enrollment form.