NORTHWEST INSULATION WORKERS WELFARE TRUST

ENROLLMENT FORM

PLEASE PRINT **F55**

IMPORTANT: Please complete this form in its entirety, listing all eligible dependents (spouse and/or children) you wish to cover. This form will replace any other enrollment form on file at the Administration Office. It is necessary to provide copies of documentation such as a marriage certificate, birth certificate, adoption decree, legal guardianship, and/or parenting plan if applicable. If removing a spouse, provide a copy of the divorce decree, decree of legal separation or death certificate. NOTE: Additional documentation may be requested by the Administration Office. **Due to ACA/IRS reporting requirements, you must provide your social security number and all dependents' social security numbers. If you do not provide the required social security numbers, this form will be returned to you.**

Indicate reason for completing this form:
☐ New Participant ☐ Address Change ☐ Add/Term Dependent(s) ☐ Change Name

MEMBER/EMPLOYEE INFORMATION - PLEASE PRINT

Name (Last, First, Middle Initial)		Social Security Number	
Mailing Address		Birth Date	Sex: ☐ M ☐ F
City	State	Zip	
E-mail Address		Phone Number	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	If married, date of marriage:	If divorced, date of divorce:	

OTHER INSURANCE INFORMATION

Are you, your spouse, or other dependents covered by any other group medical insurance plan including Medicare? ☐ Yes ☐ No If Medicare, a copy of Medicare ID card must be on file with the Administration Office.				
If "yes", please provide other insurance information: Name of Subscriber with Other Coverage:				Subscriber Soc. Sec. No.
Name and Address of Other Insurance Company:				Policy or ID Number:
Other insurance covers:	☐ Subscriber	☐ Spouse	☐ Children	Date other coverage began:
Other insurance includes:	☐ Medical	☐ Dental	☐ Vision	

MEMBERS OF MY FAMILY TO BE COVERED BY HEALTH & WELFARE (see back for dependent definition)

FULL NAME OF ELIGIBLE DEPENDENT(S)	BIRTH DATE	SEX M / F	SOCIAL SECURITY NUMBER	RELATIONSHIP	Check if step, foster or adopted child

I hereby certify that the above information is true, correct and complete to the best of my knowledge. I also certify that all claims submitted will be only for myself or for my dependents who are eligible for benefits under the plan. I understand that I will be responsible for reimbursement to the Trust Fund for all amounts paid in connection with claims for me or my dependents if I make any false statements or misrepresentation in this form or in any other claim form or if I conceal any information pertaining to any such claims. I agree to provide to the Trust Fund, upon request, with verification of any information.

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

Return one (1) copy to the Administration Office, PO Box 34203, Seattle WA 98124-1203; or
Scan and Email to: Enrollment@wpas-inc.com; or Fax to: 206-505-9727
Retain one (1) copy for your records

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NOTICE

Please be advised that this form MUST be signed by the participating Member to be valid.

DEFINITION OF DEPENDENT ELIGIBILITY

A dependent is:

- An eligible Employee's legal spouse.
- An eligible Employee's natural (biological) children; stepchildren; legally adopted children and children placed with you for adoption; foster children; any children for whom you are responsible under court order; grandchildren in your court-ordered custody; and any other child with whom you have a parent-child relationship, who are under the age of 26; or
- Who turned age 26 while covered under this program and is fully handicapped. Refer to the Handicapped Dependent Children section of the Plan booklet for more detailed information and requirements.
- A dependent child covered Qualified Medical Child Support Orders (QMCSO).

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