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

_____ ❑ Single
Address *(Mailing)* ❑ Married _____
Date Married

_____ _____ _____ ❑ Divorced _____
City — State — Zip Code — Date Divorced

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

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 ❑ Female ❑	❑ Yes ❑ No
					- -	Male ❑ Female ❑	❑ Yes ❑ No
					- -	Male ❑ Female ❑	❑ Yes ❑ No
					- -	Male ❑ Female ❑	❑ Yes ❑ No
					- -	Male ❑ Female ❑	❑ Yes ❑ 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 ❑ Female ❑	❑ Yes ❑ No
					- -	Male ❑ Female ❑	❑ Yes ❑ No
					- -	Male ❑ Female ❑	❑ Yes ❑ 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.

× ______ PARTICIPANT'S SIGNATURE

______ DATE SIGNED

ADMINISTRATIVE USE ONLY

Date: ______

Initials: ______