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: _____

PARTICIPANT DATA

LAST NAME	FIRST NAME	MIDDLE INITIAL
SOCIAL SECURITY NUMBER	MALE ☐ FEMALE ☐	DATE OF BIRTH
MAILING ADDRESS	CITY, STATE, ZIP	HOME PHONE NUMBER

MARITAL STATUS

SINGLE ☐	MARRIED ☐ Date of Marriage:	DIVORCED ☐ Date of Divorce:	Widowed ☐

EMPLOYER (COMPANY NAME)	DATE OF HIRE	LOCAL UNION NO.

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 or domestic partner.

   NOTES: A. You may enroll a domestic partner ***only if*** your employer provides domestic partner coverage. If enrolling in the Trust Plan and have not previously enrolled your domestic partner, you must also obtain and attach the Trust's Affidavit of Domestic Partnership and required proof of domestic partnership (refer to affidavit for list of acceptable proof); B. You may elect to not list a spouse only due to death, divorce, or legal separation or if your spouse consents to not being covered (documentation may be required).

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.

3. 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.

NOTE: When enrolling a NEW dependent only, the Plan requires all Participants to submit documentation to verify dependency status as described above. Claims submitted on behalf of dependents that have not been verified ***will not be paid*** until the required documentation has been submitted. *If you have previously verified your dependent's eligibility* you do not need to submit documentation again. Contact the Trust's administrative office if you have questions regarding whether you have previously verified a dependent or what documentation is required. Such documentation may include, but is not limited to:

Spouse – *Marriage Certificate*	Child – *Birth Certificate/Proof of Adoption*	Ward – *Guardianship Papers*

If adding a NEW, please submit copies of the required documentation for each dependent along with this form.

Please read #2 and #3 above before listing children. LAST NAME FIRST INITIAL	DATE OF BIRTH	RELATION	SOCIAL SECURITY NO.	GENDER		DOES CHILD LIVE WITH YOU?	
				MALE	FEMALE	YES	NO
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

IF YOU HAVE ADDITIONAL DEPENDENTS PLEASE ATTACH A SEPARATE SHEET OF PAPER

PLEASE COMPLETE REVERSE SIDE. PARTICIPANT MUST SIGN AND DATE FORM.

COUNTY USE ONLY:

Account #	Union	Coverage
☐ 107054	MCBA	Medical, Dental Vision
☐ 107082	Corrections	Medical, Dental, Vision
☐ 110398	Unrepresented	Medical, Dental, Vision
☐ 123442	FOP – Fraternal Order of Police	Medical
☐ 123578	ProTec 17	Medical

Effective Date of Coverage:

_____

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PARTICIPANT DATA FORM – Side 2

DEPENDENT CHILDREN OF DIVORCED OR SEPARATED PARENTS

If any dependent(s) added to coverage is covered under another healthcare 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 JOINT CUSTODY, INDICATE here ☐)	BIRTH DATE OF OTHER PARENT

If divorced, did a court establish financial responsibility for the child(ren)'s health care?	YES ☐ NO ☐

If, yes, the responsible person(s) are:

NAME	STREET ADDRESS OR PO BOX	CITY, STATE, ZIP	PHONE NUBMER

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 and your dependents have no other insurance.

If you or any of your dependents have or had coverage with any other healthcare plan in the last 12 months (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 (check all that apply)	☐ Medical ☐ Dental ☐ Vision ☐ Other	☐ Medical ☐ Dental ☐ Vision ☐ Other	☐ Medical ☐ Dental ☐ Vision ☐ 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			
Street Address or PO Box			
City			
State, Zip Code			
Insurance Company Phone No.			
Group or Policy Number			
Effective Date of Coverage			
Termination Date of Coverage, if not Active			

FAILURE TO FILE OR UPDATE YOUR PARTICIPANT DATA OR SUBMIT THE REQUIRED DEPENDENT VERIFICATION DOCUMENTATION 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.

× _____

PARTICIPANT'S SIGNATURE

_____

DATE SIGNED