THE EMPLOYEES PAINTERS' TRUST HEALTH & WELFARE PLAN

104 S. Freya Suite 220 White Flag Bldg.
Spokane, WA 99202
Phone: (509) 534-0265 or 1-800-566-4455

ENROLLMENT FORM

To ensure the Trust has all of the information needed to correctly process your claims in accordance with benefit payment rules, the Trust will not release any claim payments until you have submitted a completed Enrollment Form. This information will be treated as strictly confidential and will not be released to any unauthorized party. Please complete and return an Enrollment Form when you first become eligible and whenever your family status changes, e.g., marriage, divorce, legal separation, birth or adoption of a child, child becomes ineligible due to age or losing student status.

☐ **New enrollment**

☐ Add family members. If dependent child, please attach photocopy of legal birth certificate. If addition is due to marriage, give marriage date _______________ (Please attach a photocopy of marriage certificate.)

☐ Delete family members. If deletion is due to death, divorce, or legal separation, please see below.

☐ Address Change ☐ Beneficiary Change ☐ Change of Name (provide legal documentation)

1. Employee's Name (Please Print) ☐ Male ☐ Female

____
Last First Middle Initial

☐ Married Date Married ______________________ Date of Birth ______________________

☐ Single ☐ Separated ☐ Divorced ☐ Widow(er)

2. Mailing Address ____
Number Street City State Zip

3. Social Security Number ________________ Home Phone No. ________________ Local Union No. ________________

4. Employer's Name ________________________________ Date employed ________________

5. Please list ALL family members eligible for coverage, including spouse.

	Last Name	First	Middle	Birthdate	Relationship	Gender	Social Security No.
Spouse:							
Child 1:							
Child 2:							
Child 3:							
Child 4:							
Child 5:							

DELETION OF FAMILY MEMBERS

Please list all Family Members you wish to remove from the Plan:

Name	Reason (i.e., death, divorce, etc.)	Effective Date

If deletion is due to death, divorce or legal separation, please be sure to enclose necessary documents, e.g. death certificate, divorce decree, etc.

FRAUD NOTICE

I understand that the Trust Fund is relying on my answers on this form. I represent, under penalty of perjury, that the answers given to all questions on this form are true and accurate. I understand that if I knowingly and with intent to defraud the Trust Fund, provide any materially false information or conceal, for the purpose of misleading, information concerning any fact material thereto, I may be subject to civil and criminal penalties.

I hereby certify that the foregoing statements, including any accompanying statements and/or documents, are true, correct and complete to the best of my knowledge, and hereby further authorize my Provider of services to release any medical or other information necessary to process claims. A photocopy will be considered the same as the original.

MEMBERS SIGNATURE X ________________________________ **DATE** ________________

(Over)

THE EMPLOYEES PAINTERS' TRUST HEALTH & WELFARE PLAN
BENEFICIARY INFORMATION

This is to certify that I hereby revoke all former beneficiary designations, if any, and name the following as beneficiary for any death benefit payable under THEEMPLOYEES PAINTER'S TRUST HEALTH & WELFARE PLAN. You may designate anyone as beneficiary for your life insurance. However, if you are married and the beneficiary you choose is not your spouse, your spouse must consent to the designation by signing below

Primary Beneficiary: ____________________
Last Name First Initial

Address: ____________________
City State Zip Code

Date of Birth: __________ Social Security Number: __________ Relationship: __________

Contingent Beneficiary: ____________________
Last Name First Initial

Address: ____________________
City State Zip Code

Date of Birth: __________ Social Security Number: __________ Relationship: __________

Signature of Spouse (if required): ____________________

HEALTH & WELFARE PLAN

This is to certify that I hereby revoke all former beneficiary designations, if any, and name the beneficiaries listed above.

____________________ ____________________
Participant Signature Date

OTHER INSURANCE INFORMATION

Coordination of benefits sets forth rules for the order of payment of Expenses when two or more plans – including Medicare – are paying. When an Insured Person is covered by this Plan and another plan, or the Insured Person's spouse is covered by this Plan and by another plan or the couple's covered children are covered under two or more plans the plans will coordinate benefits when a claim is received.

Are you, your spouse, or other family member covered by any other medical, dental or vision Plan? Yes ☐ No ☐

If yes, is the coverage through employment? Yes ☐ No ☐ Name of other health insurance carrier: ________________________

Type of coverage: Medical ☐ Prescription ☐ Dental ☐ Vision ☐

Name of Insured of other coverage: ___________________________________ Relationship to our Insured: ___________________________

Which family members are covered under the other coverage? ____

Please note: If there is a divorce decree or parenting plan that affects these coverages, a copy will be required for the Trust office to determine which coverage is primary.

If you wish to change your designated beneficiary, you must file a new Benefit Designation Form*

Contact the Administrative Office

(Over)