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.

ADMINISTRATIVE USE ONLY
Date: _______________
Initials: _______________

RETURN TO:
HUMAN RESOURCES

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

PARTICIPANT DATA

_____ – _____ – _____ Social Security Number

❑ Male ❑ Female

_______________ Date of Birth

_______________ Participant Last Name

_______________ First Name

_______________ Middle Initial

_______________ Mailing Address

❑ Single
❑ Married – date: _______________
❑ Divorced – date: _______________

_______________ City

_______________ State

_______________ Zip Code

_______________ Employer (Company Name)

_______________ Date of Hire

_______________ Union Local No.

_______________ Home Phone Number

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.
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. ***Note: Employees participating in a grandfathered Medical Plan through the Trust (Plans JC28XL or WT100) may not cover a child ages 19-25 under any of their Trust coverage until July 1, 2014 if the child has access to other employer sponsored health coverage through the child's own employment. If you do not know which plan your medical coverage is under, please refer to your collective bargaining agreement, or contact the Trust Office, your employer, or local union.***
3. Your domestic partner *if your employer provides domestic partner coverage*. Attach the Washington Teamsters Welfare Trust's Affidavit of Domestic Partnership and required proof of domestic partnership (refer to affidavit for list of acceptable proof).
4. 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. ***Please attach proof of dependency or guardianship.***

Proof may be requested if determined necessary; i.e. birth certificate, guardianship papers, proof of incapacity, marriage certificate, divorce papers, etc.

Please read #2 and #4 above before listing children. Last Name / First / Initial	Date of Birth	Relation	Social Security No.	Gender	Does child live with you?
			- -	M❑ F ❑	Yes ❑ No ❑
			- -	M❑ F ❑	Yes ❑ No ❑
			- -	M❑ F ❑	Yes ❑ No ❑
			- -	M❑ F ❑	Yes ❑ No ❑
			- -	M❑ F ❑	Yes ❑ No ❑
			- -	M❑ F ❑	Yes ❑ No ❑
			- -	M❑ F ❑	Yes ❑ No ❑
			- -	M❑ F ❑	Yes ❑ No ❑
			- -	M❑ F ❑	Yes ❑ No ❑
			- -	M❑ F ❑	Yes ❑ No ❑

PLEASE COMPLETE REVERSE SIDE. PARTICIPANT MUST SIGN AND DATE FORM

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 a court establish financial responsibility for the child(ren)'s health care? ❑No ❑Yes, the responsible person(s) are:

Name _____ Street Address or PO Box _____

City _____ State _____ Zip Code _____ Phone Number _____

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 or your dependents have no other insurance.

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.

	Policy No. 1	Policy No. 2	Policy No. 3
Type of Healthcare Coverage	❑ 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			
Insurance Co. Street Address or PO Box			
City State, Zip Code			
Insurance Company Phone No.			
Group or Policy Number			
Effective Date of Coverage			

FAILURE TO FILE OR UPDATE YOUR PARTICIPANT DATA 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.

If I participate in a grandfathered Medical Plan through the Trust (Plan JC28XL or WT100), I also certify that any child ages 19-25 listed on the front of this form does not have access to other employer sponsored health coverage through the child's own employment.

× _____ _____

PARTICIPANT'S SIGNATURE DATE SIGNED