

WESTERN STATES HEALTH & WELFARE TRUST OF THE OPEIU

1220 SW Morrison, Suite 300 Portland, OR 97205-2222 Phone (503) 224-0048 or (800) 547-4457, ext. 1678

MEDICAL PLAN DESIRED

- LIFEWISE PPO PLAN (MEDICAL) & EXPRESS SCRIPTS (RX)
- KAISER PERMANENTE

DENTAL PLAN DESIRED

- TRUST DENTAL PLAN
- KAISER PERMANENTE
- WILLAMETTE DENTAL

I am applying:

- For open enrollment
- For new enrollment (Marriage and Birth Certificate Required)
- To add family members - If addition is due to marriage, give marriage date _____ (Marriage or Birth Certificate Required)
- To delete family member due to death; give date of death _____
- To delete family member due to divorce; give date of divorce _____ (Divorce Decree Required)

Note: Choice of coverage is offered to new employees or during Open Enrollment

When completing this form, if you require additional space, please add a page.

EMPLOYEE INFORMATION (This section must always be completed when enrolling for the first time or making changes)

Employee Last Name		First Name	MI	SEX F <input type="checkbox"/> M <input type="checkbox"/>	Date of Birth	Local Union #
Social Security#		Employer		Email Address		Hire Date
Home Address			City	STATE	ZIP	Home Phone ()
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed						Work Phone ()
Date of Marriage:				Date of Divorce or Death of Spouse:		

DEPENDENT INFORMATION All information requested must be completed. If any item is not applicable, write "N/A"

A d d e r m	T e r m	Relationship (Spouse, Son, Daughter)	Last Name	First Name	MI	SS#	Date of Birth MO/DA/YR

FULL TIME STUDENT AGE 21-23

Student's Name	School & City	# Of Credit Hours	Anticipated Graduation

OTHER ENROLLMENT INFORMATION (This information is required for payment of claims.)

Do you or your family members have other group health insurance? NO YES Medicare? NO YES

If yes, check the types of coverage provided: Medical Dental Orthodontia Vision Rx

PLEASE ALSO COMPLETE THE FOLLOWING	Name of Policyholder	Policyholder Birth date	Insurance Carrier Name/Address	Carrier Phone No
Is the insurance of any above dependents by a divorce decree/court order? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please include the portion of the decree that shows responsibility for medical expenses.		First Names of Persons Covered	Policy No.	Effective Date

***CHILD CUSTODY INFORMATION :** An employee's unmarried children, or sibling in the custody of the employee and for whom the employee is providing the majority of his or her support will be considered a dependent if the employee has been named as legal guardian by a court of competent jurisdiction, until the end of the month the child, or sibling attains age 21. Coverage for the child, or sibling can continue beyond age 21 if the child, or sibling meets the definition of full-time student or incapacitated child as defined in the benefit booklet.

I certify that I have read the instructions and that the above information is complete and accurate. 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 to reimburse 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 claim form or if I conceal any information pertaining to any such claims. I agree to provide the Trust Fund, upon request, with verification of any information.

PLEASE SIGN X

Date Signed