NORTHWEST ROOFERS & EMPLOYERS HEALTH & SECURITY TRUST FUND

PLEASE PRINT **ENROLLMENT/BENEFICIARY FORM** **F26**

IMPORTANT: Please complete this form in its entirety, **listing all eligible dependents** (spouse and/or children) and current beneficiary. **This form will replace any other enrollment/beneficiary form on file at the Administration Office.** It is necessary to provide copies of documentation such as a marriage certificate, birth certificate, adoption decree, legal guardianship, and/or parenting plan if applicable. If removing a spouse, provide a copy of the divorce decree or death certificate. **NOTE:** additional documents may be requested by the Administration Office. **Due to ACA/IRS reporting requirements, you must provide your social security number and all dependents' social security numbers. If you do not provide them, this form will be returned to you for completion.**

☐ Address Change ☐ Name Change_____ ☐ Change Dependent(s) ☐ Change Beneficiary
previous name

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX M/F	BIRTHDATE (Mo/Day/Year)	RELATIONSHIP to SUBSCRIBER	Check if Step, Foster or Adopted Child
Member				Self	
Spouse				**Date of Marriage**	
Eligible Dependents (see back for definition)					
Mailing Address (Street or PO Box, City, State, Zip Code)					
Email Address			**Phone No.**		

1. Are you, your spouse, or other dependents covered by any other group medical insurance plan including Medicare?

YES _____ NO _____

If "yes," please provide the information requested. If Medicare, copy of Medicare ID card must be on file with the Administration Office.

Name of Subscriber with Other Coverage Soc. Sec. No. Policy or I.D. Number

Name and Address of other Insurance Company City State Zip

2. Insurance covers: ☐ Subscriber ☐ Spouse ☐ Children

3. Other coverage includes: ☐ Medical ☐ Dental ☐ Vision

BENEFICIARY DESIGNATION

You may name anyone as your Beneficiary to receive benefits from the Trust. However, in community property states, your surviving spouse is entitled to any community property interest in your benefits.

LIFE INSURANCE

Beneficiary Name _____
(Last Name) *(First Name)*

Beneficiary Address _____
(Street) *(City)* *(State)* *(Zip)*

I hereby certify that the above information is true, correct and complete to the best of my knowledge and supersedes any beneficiary designation signed prior to the date shown below.

_____ Date _____
Signature ***(must be signed by participating member)***

RETURN A COPY TO THE ADMINISTRATION OFFICE: P.O. BOX 34203 · SEATTLE, WA 98124-1203
Or scan and email to: Forms@wpas-inc.com or Fax to: (206) 505-9727

NOTICE

Please be advised that this form MUST be signed by the participating Member for beneficiary designations to be valid.

DEFINITION OF DEPENDENT ELIGIBILITY

Eligible dependents shall be the employee's legal spouse and children including step-children, foster children, adopted children, children placed with the employee or spouse for adoption, and children who depend on you by virtue of a court order or for whom you have legal custody, up to 26 years of age (regardless of whether the dependent is married, a full-time student, resides with the employee or retiree, or is financially dependent on the employee or retiree). **NOTE:** This plan will pay secondary to a plan that covers a dependent as an active employee. Employees are not eligible as dependent children.