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, please provide copy with this form.

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 WHITE COPY TO THE ADMINISTRATION OFFICE: P.O. BOX 34203 · SEATTLE, WA 98124-1203
Or scan and email to: enrollment@wpas-inc.com or Fax to: (206) 505-9727
RETAIN YELLOW COPY FOR YOUR RECORDS