AGC-International Union of Operating Engineers Local 701 Health and Welfare Trust Fund

PLEASE PRINT **ENROLLMENT FORM** **F07**

IMPORTANT: Please complete this form in its entirety, listing all eligible dependents (spouse and/or children) and current beneficiary. This form will replace any previous enrollment/beneficiary form on file at the Administration Office.

SECTION I: MEDICAL AND DENTAL PLAN ELECTIONS

Indicate your Medical Plan coverage election (may only be changed at annual Open Enrollment):
☐ AGC-IUOE Local 701 Health & Welfare Plan (Trust Coverage) ☐ Kaiser Permanente (Must live within the HMO service area)

Indicate your Dental Plan coverage election (may only be changed at annual Open Enrollment):
☐ AGC-IUOE Local 701 Health & Welfare Plan (Trust Coverage) ☐ Willamette Dental (Must live within OR, WA or ID)

SECTION II: SPECIAL ENROLLMENT ONLY (Enrollment outside of annual Open Enrollment period)

PURPOSE FOR COMPLETING FORM:
☐ New Employee ☐ Address Change ☐ Change Beneficiary
☐ Name Change* - Previous Name: _____
☐ Add the Following Dependent(s): _____

If adding dependent(s), circle qualifying event*: Birth / Marriage / Adoption / Loss of Coverage / Other: _____
*Please attach appropriate documentation with this form. If adding a spouse, you must send in a copy of your marriage certificate. If adding dependents, you must send in a copy of birth certificate(s).

SECTION III: EMPLOYEE AND DEPENDENT** INFORMATION (To be completed by all Enrollees)

LIST EMPLOYEE AND SPOUSE** TO BE COVERED (Last Name, First Name, Middle Initial)	SOCIAL SECURITY NUMBER	SEX	BIRTHDATE (Month/Day/Year)
Employee:			
Mailing Address (If a spouse has a different address than the employee, complete the last portion of this form.)			
Spouse:			
☐ **Single** ☐ **Married** ☐ **Divorced**	**If Married, date of Marriage:**	**If Divorced, date of Divorce:**	
Phone Number:	**E-mail Address:**		

LIST DEPENDENT CHILDREN**TO BE COVERED (If any dependent child has a different address than the employee, complete the last portion of this form.)	SOCIAL SECURITY NUMBER	SEX	BIRTHDATE (Month/Day/Year)	INDICATE IF DEPENDENT IS A STEPCHILD, FOSTER CHILD, OR GRANDCHILD**
1. ** (SEE BACK FOR DEFINITION)				
2.				
3.				
4.				

1. Are you, your spouse, or other dependents covered by any other group medical, prescription drug, dental or vision plan, including Medicare or, are you or a dependent eligible to enroll in Medicare? ☐ Yes ☐ No If eligible to enroll in Medicare but declined, list date eligible to enroll in Medicare: _____
(*If yes, please provide information below.) If Medicare, a copy of the Medicare ID card must be on file with the Administration Office.*

Name of Subscriber with Other Coverage | Social Security Number | Policy or I.D. Number

Name and Address of other Insurance Company | City | State | Zip

2. Insurance covers: ☐ **Subscriber** ☐ **Spouse** ☐ **Children**

3. Coverage includes: ☐ **Medical** ☐ **Dental** ☐ **Vision** ☐ **Prescription Drug**

(over)

SECTION IV: LIFE INSURANCE BENEFICIARY DESIGNATION

NAME OF BENEFICIARY (Last Name, First Name, Middle Initial)	**MAILING ADDRESS** (Street or P.O. Box, State, Zip Code)	**SOCIAL SECURITY NUMBER**	**BIRTHDATE** (Month/Day/Year
Primary Beneficiary:			
Beneficiary if Primary Beneficiary is Deceased upon Participant's Death:			

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.

Signature *(must be signed by employee and should be dated for beneficiary designations to be valid)* **Date**

Complete the following section only if your spouse or any dependent child has a different address than your own.

LAST NAME, FIRST NAME, MIDDLE INITIAL	**MAILING ADDRESS** (Street or P.O. Box, State, Zip Code)
Spouse:	
Dependent Child:	
Dependent Child:	
Dependent Child:	
Dependent Child:	

Return to the Trust Office at PO Box 34203, Seattle, WA 98124-1203
or Scan and Email to: enrollment@wpas-inc.com

PLEASE CALL THE TRUST OFFICE AT 1-866-697-5750 IF YOU HAVE QUESTIONS

DEFINITION OF DEPENDENT ELIGIBILITY

**Dependent Information.

Eligible dependents include your legal spouse and dependent children through age 25. "Children" means those individuals in the following categories who qualify as your federal tax dependents for group health plan purposes: your natural children, adopted children, children who were placed with you for adoption under the age of 19, stepchildren, foster children, and children who are to have coverage as a result of qualified medical child support order. Grandchildren (and children of dependent children) will only be considered for eligibility under the Plan if you (or your Spouse) have legal guardianship of such children, and even in that case, coverage is not automatic. If you indicate that an individual for whom you are seeking enrollment in the Plan is a stepchild, foster child, or grandchild, the Trust Office will contact you to inform you of additional eligibility requirements. Claims will not be paid until a completed enrollment form and all requested supporting documentation is received by the Trust Administration Office. In no event will claims be paid more than 12 months after the claims are incurred. If you acquire new dependents while you have coverage, a new enrollment form must be completed and submitted along with the appropriate documentation. You should complete a new enrollment form and supply an appropriate marriage or birth certificate within 30 days of your marriage, the birth of the child, or adoption or placement for adoption or as soon as reasonably practicable. Claims will not be paid until a completed enrollment form and all requested supporting documentation is received by the Trust Administration Office.