WASHINGTON TEAMSTERS WELFARE TRUST

ANNUAL OPEN ENROLLMENT FORM - 2015

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.

MAIL TO: Washington Teamsters Welfare Trust - 2323 Eastlake Avenue East - Seattle WA 98102-3393

ADMINISTRATIVE USE ONLY
Date: ______________
Initials:_____________

PARTICIPANT DATA

Social Security or ID Number ______________ ❑ Male ❑ Female Date of Birth ______________

Participant Last Name ______________ First Name ______________ Middle Initial ______________

Mailing Address ______________

❑ Single
❑ Married – date:____________________
❑ State-registered domestic partnership
❑ 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 eligible family member as described below. Otherwise list ALL of your family described in #1, #2, and #3.

1. **Spouse or domestic partner.**

   NOTES: A. You may enroll a domestic partner ***only if*** your employer provides domestic partner coverage. If enrolling in the Trust Plan and have not previously enrolled your domestic partner, you must also obtain and attach the Trust's Affidavit of Domestic Partnership and required proof of domestic partnership (refer to affidavit for list of acceptable proof); B. You may elect to not list a spouse only due to death, divorce, or legal separation or if your spouse consents to not being covered (documentation may be required).

2. **Natural, adopted, and step children under 26 years of age *or* incapable of self-support due to mental or physical incapacities.** Documentation may be required.

3. **Your grandchildren, children for whom you have been appointed guardian by the court, and children of your domestic partner *(if your domestic partner is covered)* who are either (a) under 19 years of age, unmarried, live with you, and are dependent on *you* for support and maintenance, or (b) meet all the conditions of 'a' but are either 19 through 25 years of age and also full-time students in an accredited educational institution, or (c) incapable of self-support because of mental or physical incapacities**. Documentation may be required.

Last Name First Initial	Date of Birth	Relation	Social Security No.	Gender	Child lives 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 ❑

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 ______

Name ______ Street Address or PO Box ______ City ______ State ______ Zip ______

PLEASE COMPLETE REVERSE SIDE. PARTICIPANT MUST SIGN AND DATE FORM