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IBEW HEALTH & WELFARE TRUST OF SOUTHWEST WASHINGTON

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PARTICIPANT DATA FORM

ALL INFORMATION IS REQUIRED

PARTICIPANT INFORMATION

Name of Participant:		**Employer:**	
Social Security Number:	☐ M ☐ F	**Date of Birth:**	**Date of Enrollment or Change:**

Type of Enrollment:

☐New Enrollment ☐Marriage ☐Divorce ☐Death ☐Birth/Adoption ☐Other (please specify) _____

Legal documentation is required for all new enrollments and any changes made:

☐Birth Certificate ☐Marriage Certificate ☐Divorce Decree ☐Adoption Paperwork ☐Recent Federal Tax Return ☐Death Certificate

Address:

_____
(Street address or PO Box Number)

_____
(City, State, ZIP Code)

Telephone:

Home: (_____) _____

Cell: (_____) _____

Email: _____

SPOUSE/DOMESTIC PARTNER AND DEPENDENT INFORMATION

Add	Drop	Relationship to Participant	Last Name	First Name	Middle Initial	Social Security Number	Date of Birth (mo/day/year)	Gender
☐	☐							☐ M ☐ F
☐	☐							☐ M ☐ F
☐	☐							☐ M ☐ F
☐	☐							☐ M ☐ F
☐	☐							☐ M ☐ F
☐	☐							☐ M ☐ F
☐	☐							☐ M ☐ F
☐	☐							☐ M ☐ F
☐	☐							☐ M ☐ F

Is any child over the dependent age limit applying for coverage due to disability? ☐ No ☐ Yes*

* If yes, *complete and attach the Request for Certification of Disabled Dependent form.*

Does any dependent have a different mailing address? ☐ No ☐ Yes→ _____
List Dependent name

_____
Write in Dependent mailing address including City, State and ZIP Code

OTHER COVERAGE INFORMATION

Do you, your spouse/domestic partner or covered dependents have other coverage available for:

Medical: ☐No ☐Yes **Dental:** ☐No ☐Yes **Vision:** ☐No ☐Yes **Prescriptions:** ☐No ☐Yes **Medicare:** ☐No ☐Yes

COVERAGE #1:

Enrollee's Name:_____ Enrollee's Birth Date: _____ Plan Name: _____

Plan Phone Number:_____ Effective Date: _____ Termination Date: _____

COVERAGE #2:

Enrollee's Name:_____ Enrollee's Birth Date: _____ Plan Name: _____

Plan Phone Number:_____ Effective Date: _____ Termination Date: _____

COVERAGE #3:

Enrollee's Name:_____ Enrollee's Birth Date: _____ Plan Name: _____

Plan Phone Number:_____ Effective Date: _____ Termination Date: _____

✸ ✸ ***MUST COMPLETE AND SIGN FORM ON REVERSE SIDE*** ✸ ✸

SPOUSAL/DOMESTIC PARTNER COVERAGE

Participant Complete this Section IF YOU ARE ENROLLING A SPOUSE/DOMESTIC PARTNER

Certification of Spousal Coverage

Please check the appropriate statement:

Does your spouse/domestic partner have medical plan coverage **available** through his or her employment?

☐ No → *Sign Certification below*

☐ Yes →*Complete **all** of the questions and sign Certification below:*

1. *Is your spouse/domestic partner is currently **covered** under his or her employer's medical plan coverage?*

   ☐ Yes

   ☐ No →*When can he or she next enroll?* _____

2. *List your spouse/domestic partner's employer:*

   _____

CERTIFICATION

I attest that the information provided in this Certification of Spousal Coverage is accurate and truthful. I authorize the Trust Fund or its agents to verify coverage with my spouse/domestic partner's medical plan.

Sign Here →

_____	_____	_____
Participant's Signature	*Print Name*	*Date*

Sign Here →

_____	_____	_____
Spouse/domestic partner's Signature	*Print Name*	*Date*

REQUIRED SIGNATURE

I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted.

Sign Here →

_____	_____	_____
Participant's Signature	*Print Name*	*Date*

Don't forget to include any required documentation for New enrollments only

Marriage Certificate	Birth Certificate	DSHS Paperwork
Recent Federal Tax Return	Divorce Decree	Death Certificate
Domestic Partner Affidavit *(please contact the Trust office)*	Adoption Paperwork	I-9 Documents

REHN & ASSOCIATES