# WASHINGTON-IDAHO OPERATING ENGINEERS AND EMPLOYERS HEALTH & SECURITY TRUST FUNDSPLEASE PRINTENROLLMENT FORMF81

**Important:** Please complete this form in its entirety (front and back), 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 your divorce decree or death certificate. Eligibility will not be granted to dependents until all documents are received.

New Participant	□ Address Change	□ Name Change	$\Box$ Add/Change Dependent(s)
Add/Change Benefici	iary		

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX	BIRTHDATE (Mo/Day/Year)	RELATIONSHIP to SUBSCRIBER	Check if Step, Foster or Adopted child
Member				Self	
Spouse				Date of Marriage	
Eligible Dependents See reverse side for additional space.					
Mailing Address (Street or PO Box, City, State, Zip of paper.	Code) <i>If any dependent i</i>	has a se	parate address, pleas	se provide it on an add	litional sheet
E-mail Address:	Home Phone N	Home Phone No: Cell 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, a copy of Medicare ID card must be on file with the Administration Office. If separate coverages apply to different dependents, please provide additional coverage information on an additional sheet of paper.

Name of Subscriber with Other Coverage	Soc. Sec. No.	Policy or I.D. Number
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Name and Address of other Insurance Company\_\_\_\_\_City\_\_\_State\_\_\_Zip\_\_\_\_

2. Insurance covers: 
Subscriber 
Spouse 
Children 3. Coverage includes: 
Medical 
Dental 
Vision 
Rx

**DENTAL PLAN ELECTION – ACTIVE PARTICPANTS ONLY:** If you are new to the Plan, please check the appropriate box below.

□ I elect to be covered under the **Willamette Dental Plan**. I understand that my family must receive all care at a Willamette Dental Center.

 $\Box$  I elect to be covered under the **Delta Dental Plan**..

PLEASE NOTE: You may only change your dental selection during the open enrollment period prior to January 1. If you do not elect a Plan you will automatically be enrolled in the Delta Dental Plan.

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

Date \_\_\_\_

Signature (must be signed by participating member for eligible dependents to be valid)

## **BENEFICIARY DESIGNATION**

**PLEASE NOTE:** Under the Retirement Plan, if you are married on your date of death, your spouse will automatically receive any preretirement death benefit you may be eligible to receive. In community property states, your surviving spouse is also entitled to any community property interest in Health and Security benefits. If you select an ineligible beneficiary or do not designate a beneficiary, your death benefit(s) (if any) will be paid in the order of preference outlined in the applicable Plan booklet.

□ Engineers-AGC Retirement Trust Fund of the Inland I RETIREMENT PLAN - PRERETIREMENT DEATH BENEFIT (If not married, you may name anyone.)	st Fund
DETIDEMENT DI AN DEEDETIDEMENT DE ATH DENEEIT (If not married you may name anyone)	Empire
<b>RETIREVIENT FLAN</b> - FRERETIREVIENT DEATH DENEFTT (II not marned, you may name anyone.)	
Beneficiary: Relationship	
Address: Social Security No	
HEALTH & SECURITY - LIFE INSURANCE (You may name anyone.) Beneficiary: Relationship	
Address: Social Security No	

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 for beneficiary designations to be valid)

#### HEALTH AND SECURITY PLAN DEFINITION OF ELIGIBLE DEPENDENT

Your eligible dependents are covered whenever you are covered or the date a dependent is acquired, if a later date. Eligible dependents are your:

- Spouse. A spouse is not a legally separated spouse or a domestic partner.
- Son, daughter, stepchild, foster child, adopted child, child placed with you for adoption, who is under the age of 26 (regardless of whether the dependent child 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 be secondary to a plan that covers a dependent as an active employee.
- Unmarried children who depend on the employee or retiree by virtue of a court order or for whom the employee or retiree has legal custody are considered eligible dependents up to the age of 19 (or up to age 24 if a full-time student).
  - If a covered Dependent child upon attainment of the limiting age for Dependent children is and continues to be:
  - A. Incapable of self-sustaining employment by reason of mental or physical handicap; and

B. Chiefly dependent on the individual for support and maintenance, Medical coverage for such child shall be continued beyond the limiting age during such continuing dependency provided proof of such incapacity and dependency is furnished to the Trust Administrative Agent by the Employee within 31 days of the child's attainment of the limiting age and subsequently as may be required by the Trust but not more frequently than annually after the two year period following the child's attainment of the limiting age.

# Refer to your Plan booklet for more detailed dependent eligibility information.

## List additional dependents below:

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX	BIRTHDATE (Mo/Day/Year)	RELATIONSHIP to SUBSCRIBER	Check if Step, Foster or Adopted child