WASHINGTON-IDAHO OPERATING ENGINEERS AND EMPLOYERS HEALTH & SECURITY TRUST FUNDS

PLEASE PRINT **ENROLLMENT FORM** **F81**

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 _____ □ Add/Change Dependent(s)
□ Add/Change Beneficiary

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 Code) ***If any dependent has a separate address, please provide it on an additional sheet of paper.***

E-mail Address:	**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

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.

□ I elect to be covered under the **Trust Reimbursement Dental Plan**. The Trust Plan is a scheduled reimbursement 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 Trust Reimbursement 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)***

PLEASE COMPLETE THE BENEFICIARY DESIGNATION ON THE REVERSE OF THIS FORM

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.

CHECK THE PLAN(S) YOU ARE A PARTICIPANT IN: □ **Idaho Operating Engineers & Employers Pension Trust Fund**
□ **Engineers-AGC Retirement Trust Fund of the Inland Empire**

RETIREMENT PLAN - PRERETIREMENT DEATH BENEFIT (If not married, 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

RETURN TO THE ADMINISTRATION OFFICE: PO BOX 34203 – SEATTLE, WA 98124-1203
Scan and email to: forms@wpas-inc.com or Fax to: (206) 505-9727