IRON WORKERS LOCAL NO. 5 TRUST FUNDS

PLEASE PRINT **ENROLLMENT FORM** **F57**

Important: Please complete this form in its entirety, 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, legal separation agreement, or death certificate.

☐ 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 back for definition)*					☐
					☐
					☐
					☐
Mailing Address (Street or PO Box, City, State, Zip Code)					
E-mail Address:	**Phone No:**			**Local Union 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 the Medicare ID card must be on file with the Administration Office. If separate coverages apply to different dependents, please write additional coverage information on reverse of form.

_____
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

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.

RETIREMENT PLAN - PRERETIREMENT DEATH BENEFIT (If not married, you may name anyone.)

Beneficiary _____ Relationship _____

Address: _____ Social Security No. _____

HEALTH & WELFARE - 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)***

RETURN WHITE COPY TO THE ADMINISTRATION OFFICE: PO BOX 34203 – SEATTLE, WA 98124-1203
Scan and email to: enrollment@wpas-inc.com or Fax to: (206) 505-9727
RETAIN YELLOW COPY FOR YOUR RECORDS

HEALTH AND SECURITY PLAN
DEFINITION OF ELIGIBLE DEPENDENT

Your eligible dependents are covered whenever you are covered. Eligible dependents are your:

- Lawful Spouse.
- Biological children, step-children, lawfully placed foster children, lawfully adopted children and children placed with you for the purpose of 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.
- Your unmarried, developmentally disabled and physically handicapped dependent child who is considered Totally Disabled (as defined below) and either:
  - lives with the Employee for more than one-half of the year and does not provide more than one-half of his or her own support; or
  - depends on the Employee for more than one-half of his or her financial support.
- To be covered under this provision, the Child must have become Totally Disabled prior to the date that eligibility at age 26 would have otherwise ceased. Proof of Total Disability must be submitted to the Plan Administrator.
- The eligibility for a Disabled Child will continue as long as the Child continues to be Totally Disabled. The Trustees may rely on evidence that a Child has been claimed as a Dependent on the Employee's tax return or any other evidence deemed necessary by the Board of Trustees. For continued coverage after age 26, proof must be submitted that the Disabled Child continues to be Totally Disabled. The Trustees reserve the right to terminate coverage for any individual on which proper evidence of continued eligibility is not received. It shall be in the Trustees' sole discretion to determine what evidence is sufficient to prove the child is a Disabled Child
- 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).

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