# PUGET SOUND ELECTRICAL WORKERS TRUST FUNDS

PLEASE PRINT **ENROLLMENT FORM** **F33**

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.** You must provide a copy of your marriage certificate when adding a spouse. If adding dependent children, it is necessary to provide copies of documentation such as birth certificate(s), adoption decree, legal guardianship, and/or a parenting plan if applicable. If removing a spouse, you must provide a copy of the divorce decree. **NOTE:** additional documents may be requested by the Administration Office. **Due to ACA/IRS reporting requirements, you must provide you and your dependent's Social Security Numbers, if you do not provide all requested information, this form will be returned to you.**

☐ New Employee ☐ Add Dependent(s) ☐ Name Change _____ *(previous name)*

☐ Change Beneficiary ☐ Address Change ☐ Delete Dependent(s) _____ *(dependent name)*

| **Employee Social Security No.** | **Name** *(Last, First, Middle Initial)* | **Birth Date** *(Mo/Day/Year)* | **Sex** ☐ M ☐ F |
|---|---|---|---|
| **Mailing Address** *(Street, City, State, Zip)* | **Phone Number** | **Email** | |

| DEPENDENT NAME (Last, First, Middle Initial) | SOCIAL SECURITY NUMBER | SEX | BIRTHDATE (Mo/Day/Year) | RELATIONSHIP to SUBSCRIBER | Check (X) if Step, Foster, Adopted Child or Legal Guardianship |
|---|---|---|---|---|---|
| **Spouse** | | | | Spouse | |
| **Eligible Dependents** (see back for definition) | | | | | |
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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 below. If Medicare, a copy of Medicare ID card must be on file with the Administration Office.

Name of Subscriber with Other Coverage Soc. Security No. Policy or I.D. Number

Name and Address of other Insurance Company City State Zip

2. Insurance covers: ☐ Subscriber ☐ Spouse ☐ Children

3. Other coverage includes: ☐ Medical ☐ Dental ☐ Vision

**BENEFICIARY DESIGNATION** - ***This form must be received by the Administration Office prior to your death to be valid.***

You may name anyone as your Beneficiary to receive benefits from the Trust Fund(s). However, if you are legally married as of your date of death, your surviving spouse will receive any Retirement and/or 401(k) benefits payable (if applicable). In community property states (Washington, Idaho), your surviving spouse is also entitled to any community property interest in the Health and Security Benefits. **Please note:** Not everyone participates in all Plans named below. Your beneficiary is only eligible for benefits you may be entitled to or have accrued by participating in the Plan.

**HEALTH AND SECURITY PLAN** – LIFE INSURANCE *(all employees complete)*

Beneficiary Name *(Last, First)* _____ Relationship _____

Beneficiary Address *(Street, City, State, Zip)* _____ Social Security No. _____

**RETIREMENT PLAN** – DEATH BENEFIT *(complete only if applicable)*

Beneficiary Name *(Last, First)* _____ Relationship _____

Beneficiary Address *(Street, City, State, Zip)* _____ Social Security No. _____

**401(k) SAVINGS PLAN** – DEATH BENEFIT *(complete only if applicable)*

Beneficiary Name *(Last, First)* _____ Relationship _____

Beneficiary Address *(Street, City, State, Zip)* _____ 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.

Employee Signature ***(required: must be signed by participating employee in order for form to be processed)*** Date

Return completed and signed white copy to the Administration Office via:
Mail: PO Box 34203, Seattle, WA 98124, Fax: (206) 505-9727 or Email: enrollment@wpas-inc.com
Retain a copy for your records.

## NOTICE

Please be advised that this form MUST be signed by the participating Employee and received by the Administration office prior to death for beneficiary designations to be valid.

## DEFINITION OF DEPENDENT ELIGIBILITY

You enroll eligible dependents to participate in the Plan of benefits at the same time you enroll. Eligible dependents include:

- Your lawfully married spouse.

- Your children are your natural children, stepchildren, adopted children, children placed with you for adoption, foster children and other children for whom you have legal guardianship up to age 26 (regardless of whether the child is married, a full-time student, resides with the employee or retiree, or is financially dependent on the employee or retiree). (Dependent life insurance for children ends at age 21.) Coverage is also extended up to age 26 for 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.

- Under the Omnibus Budget Reconciliation Act of 1993, the Plan recognizes Qualified Medical Child Support Orders ("QMCSO") and enrolls dependent children as directed by the order. A QMCSO is any judgment, decree or order (including a domestic relations settlement agreement) issued by a court or by an administrative agency under applicable state law which:
    - Provides child support or health benefit coverage to a dependent child, or
    - Enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the employee does not enroll the dependent child, then the non-employee parent or State agency may enroll the child.

- Your children age 26 and over, but only if all the following conditions are satisfied:
    a) The child was covered under the Plan as your dependent child immediately before attaining age 26.
    b) The child is unmarried.
    c) The child is incapable of earning a living due to mental or physical incapacity that began before the child attained age 26.
    d) You submit proof of the child's incapacity to the Administration Office within 90 days after the child attains age 26, and
    e) You provide the Trust periodic updates of the child's incapacity and marital status as required by the Trust.