UNITE HERE NORTHWEST TRUST FUNDS
Enrollment Form

The type of benefits available to you, the availability of family coverage, and the length of your coverage are determined by your collective bargaining agreement. Please complete this form in its entirety, listing all eligible dependents and current beneficiary. **This form will replace any other enrollment or beneficiary form on file at the Administration Office.**
For questions, please call **1 (844) 411-0786.**

ADMINISTRATIVE USE ONLY
Group Number: _____
Effective Date: _____
Effective Date of Change: _____
Initials: _____
Date: _____

Return completed form to: UniteHERE NW Trust Funds
2323 Eastlake Avenue E.
Seattle, WA 98102-3305
or fax to: (206) 926-2699

MEMBER PLEASE PRINT BELOW

Last Name	First Name	Middle Initial
Social Security Number	☐ Male ☐Female	Date of Birth
Mailing Address (Street or PO Box)	City, State, and Zip Code	Phone Number: ☐ Home ☐ Cell
Marital Status		
☐ Single ☐ Married Date of Marriage:	☐ Divorced Date of Divorce:	☐ Widowed
Employer (Company Name)		Date of Hire

Check All That Apply:
☐ New Member ☐ Add/Change Dependent (s) ☐ Address Change ☐ Name Change: _____ *(previous name)*
☐ Beneficiary Designation Change

If you have eligible dependents*, complete the section below. Eligible dependents include the following (see plan book for complete details):

- Your legal spouse
- Your state registered Domestic Partner, if approved by the Trust
- Your natural or adopted children under 26 years of age
- Your stepchildren, foster children or children of approved state registered Domestic Partner living with you if approved by the Trust

If any dependent has a different address than the Member, complete the back portion of this form. You will also need to attach copies of your marriage certificate to enroll your spouse, and birth certificates for any children you wish to cover.

ADD	DELETE	NAME *(Last, first and Middle Initial)*	SOCIAL SECURITY NUMBER	GENDER		BIRTHDATE	RELATIONSHIP TO MEMBER	** RECEIVING MEDICARE	
				Male	Female			Yes	No
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								
☐	☐								

****Please Complete the Section Below and Enclose a Copy of Medicare Card if You or a Dependent are Enrolled in Medicare**
Name of Individual Receiving Medicare Receiving Medicare due to End Stage Renal Disease (ESRD): ☐ Yes ☐ No Receiving Part A? ☐ Yes ☐ No If "Yes," Effective Date: _____ Receiving Part B? ☐ Yes ☐ No If "Yes," Effective Date: _____

Other Insurance Information

1. Are you, your spouse/domestic partner, or dependents covered by any other medical, dental or vision plan? ☐ Yes ☐ No If "Yes," provide the information below.		
Name of Subscriber with other coverage	Social Security Number	Policy or Identification Number
Name and Mailing Address (Street or PO Box, City, State, Zip Code) of other Insurance Company		
2. Insurance Covers: ☐ Subscriber ☐ Spouse ☐ Children	3. Coverage Includes: ☐ Subscriber ☐ Spouse ☐ Children	

***Complete this section only if your spouse or any dependent child has a different address than your own**.

Last Name, First Name, and Middle Initial	**Mailing Address** (Street or PO Box, City, State, Zip Code)
Spouse/Partner:	
Dependent Child:	
Dependent Child:	
Dependent Child:	
Dependent Child:	

BENEFICIARY DESIGNATION

PLEASE NOTE: You may name anyone as your Beneficiary to receive benefits from the Trust. However, in community property states, your surviving spouse is entitled to any community property interest in your benefits. If you select an ineligible beneficiary or do not designate a beneficiary, your death benefit(s) will be paid in the order of preference outlined in the applicable Plan booklet.

PENSION PLAN – Death Benefits (You may name anyone)

Beneficiary: Relationship:

Address (Street or PO Box, City, State, and Zip Code): Social Security Number:

HEALTH & SECURITY – Life Insurance (You may name anyone)

Beneficiary: Relationship:

Address (Street or PO Box, City, State, and Zip Code): Social Security Number:

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.

Signature **Date**

NOTICE: Please be advised that this form MUST be signed by the participating Member for beneficiary designations to be valid.