

HARRISON ELECTRICAL WORKERS TRUST FUND

1220 SW Morrison, Suite 300 Portland, OR 97205-2222 Phone (503) 224-0048 or (800) 547-4457, ext. 1679 Fax (503) 228-0149

MEDICAL PLAN DESIRED

- TRUST SELF-FUNDED PLAN
- KAISER PERMANENTE
(Kaiser application required)
- PROVIDENCE HEALTH PLAN
(Providence application required)

When completing this form, if you require additional space, please add a page.

DENTAL PLAN DESIRED

- TRUST SELF-FUNDED
- KAISER PERMANENTE
(Kaiser application required)
- WILLAMETTE DENTAL

Note: Choice of coverage is offered to new employees or during Open Enrollment

I am applying:

- For open enrollment
- For new enrollment (Marriage Certificate Required)
- To add family members - If addition is due to marriage, give marriage date _____ (Marriage Certificate Required)
- To delete family member due to death; give date of death _____
- To delete family member due to divorce; give date of divorce _____ (Copy of divorce decree Required)

EMPLOYEE INFORMATION (This section must always be completed when enrolling for the first time or making changes) Address Change

Employee Last Name	First Name	MI	SEX F <input type="checkbox"/> M <input type="checkbox"/>	Date of Birth	Local Union #
Social Security #	Employer	Hire Date	Email Address		
Home Address	City	STATE	ZIP	Home Phone ()	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Date of Marriage: _____			Date of Divorce or Death of Spouse: _____	
				Work Phone ()	

DEPENDENT INFORMATION All information requested must be completed. If any item is not applicable, write "N/A"

A d d	D e l e t e	Relationship	Social Security Number	Full, Legal First Name	MI	Full, Legal Last Name	Sex F/M	Date of Birth MO/DA/YR	Full-Time Student age 19-25?	Is this dependent covered by another plan? (See below)
		Spouse							N/A	Y <input type="checkbox"/> N <input type="checkbox"/>
		Child Natural/Adopted <input type="checkbox"/> Step Child <input type="checkbox"/> *Other _____							Y <input type="checkbox"/> N <input type="checkbox"/> Anticipated Grad. Date: _____	Y <input type="checkbox"/> N <input type="checkbox"/>
		Child Natural/Adopted <input type="checkbox"/> Step Child <input type="checkbox"/> *Other _____							Y <input type="checkbox"/> N <input type="checkbox"/> Anticipated Grad. Date: _____	Y <input type="checkbox"/> N <input type="checkbox"/>
		Child Natural/Adopted <input type="checkbox"/> Step Child <input type="checkbox"/> *Other _____							Y <input type="checkbox"/> N <input type="checkbox"/> Anticipated Grad. Date: _____	Y <input type="checkbox"/> N <input type="checkbox"/>
		Child Natural/Adopted <input type="checkbox"/> Step Child <input type="checkbox"/> *Other _____							Y <input type="checkbox"/> N <input type="checkbox"/> Anticipated Grad. Date: _____	Y <input type="checkbox"/> N <input type="checkbox"/>
		Child Natural/Adopted <input type="checkbox"/> Step Child <input type="checkbox"/> *Other _____							Y <input type="checkbox"/> N <input type="checkbox"/> Anticipated Grad. Date: _____	Y <input type="checkbox"/> N <input type="checkbox"/>

OTHER ENROLLMENT INFORMATION (This information is required for payment of claims.)

Do you or your family members have other group health insurance? NO YES Medicare? NO YES

If yes, check the types of coverage provided: Medical Dental Orthodontia Vision Rx

PLEASE ALSO COMPLETE THE FOLLOWING	Name of Policyholder	Policyholder Birth date	Insurance Carrier Name/Address	Carrier Phone No
Is the insurance of any above dependents by a divorce decree/court order? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please include the portion of the decree that shows responsibility for medical expenses.		First Names of Persons Covered		Policy No. Effective Date

***CHILD CUSTODY INFORMATION :** An employee's unmarried grandchild, niece, nephew, or sibling in the custody of the employee and for whom the employee is providing the majority of his or her support will be considered a dependent if the employee has been named as legal guardian by a court of competent jurisdiction, until the end of the month the grandchild, niece, nephew, or sibling attains age 19. Coverage for the grandchild, niece, nephew, or sibling can continue beyond age 19 if the grandchild, niece, nephew, or sibling meets the definition of full-time student or incapacitated child as defined in the benefit booklet.

I certify that I have read the instructions and that the above information is complete and accurate. I also certify that all claims submitted will be only for myself or for my dependents who are eligible for benefits under the plan. I understand that I will be responsible to reimburse the Trust fund for all amounts paid in connection with claims for me or my dependents if I make any false statements or misrepresentation in this form or in any claim form or if I conceal any information pertaining to any such claims. I agree to provide the Trust Fund, upon request, with verification of any information.

PLEASE SIGN X

Date Signed