SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 105
HEALTH & WELFARE TRUST

ENROLLMENT FORM
ZONES 5 – 8

INSTRUCTIONS: Please complete this form in its entirety, provide all information indicated and sign the form. If you elect dependent child(ren) coverage, you must make a self-payment by the 20th of the month for the month of coverage. You must enroll newly acquired child(ren) within 31 days of the date of birth, adoption or placement for adoption. Eligible dependents not enrolled within 31 days will not be covered until the 1st day of the month following receipt of a new enrollment form. **This form will replace any other enrollment designation form on file with the Administration Office.**

PLEASE PRINT OR TYPE

□ New Member □ Add/Remove Dependent(s) □ Address Change □ Name Change_____ □ Open Enrollment
(PREVIOUS NAME)

□ Basic Plan (Kaiser Plan DHMO 2000 30%) □ Premium Plan (Kaiser Plan DHMO 250 10%)

Employer	**Building Location**

MEMBER INFORMATION

Name (LAST, FIRST, MI)	**Social Security Number**	**Sex** (M/F)	**Birth Date** (MO/DAY/YR)

Mailing Address (STREET, CITY, STATE, ZIP CODE)

Home Phone Number	**Cell Phone Number**	**E-mail Address**

DEPENDENT COVERAGE ELECTION

☐ **Yes, I Elect Dependent Coverage.** I am applying for coverage for my dependent child(ren) **listed** on this form and I understand that I must make monthly payments for dependent coverage by the 20th of the month for the month of coverage.

DEPENDENT(S) INFORMATION

Name (LAST, FIRST, MI)	**Social Security Number**	**Sex** (M/F)	**Birth Date** (MO/DAY/YR)	**Check if Step, Foster and/or Adopted Child**
DEPENDENT CHILDREN				

OTHER INSURANCE COVERAGE

Are you and/or your dependents covered by any other medical, dental or vision plan, including Medicare? □ Yes □ No
If "Yes," please provide the information requested below. If you are eligible for Medicare a copy of your Medicare card must be on file.

Name of Person with Other Coverage | SS# or ID# | Policy or Group No. | Group Phone No.

Name and Address of Other Insurance Company | City | State | Zip

Other insurance covers: □ Member □ Spouse/Domestic Partner □ Children Other insurance includes: □ Medical □ Dental □ Vision

I hereby certify that the above information is true, correct and complete to the best of my knowledge and supersedes any form signed prior to the date shown below.

Signature *(must be signed by participating employee)* Date

RETURN A COPY TO: ADMINISTRATION OFFICE • P.O. BOX 34203 • SEATTLE, WA 98124-1203
OR SCAN AND E-MAIL TO:ENROLLMENT@WPAS-INC.COM • OR FAX TO: 206-505-9727

RETAIN A COPY FOR YOUR RECORDS