ALASKA U.F.C.W. HEALTH AND WELFARE AND PENSION TRUSTS

ENROLLMENT-DECLANATION OF COVERAGE-BENEFICIARY-DEPENDENT COVERAGE AUTHORIZATION FORM

F45

ANSWER ALL QUESTIONS & RETURN IMMEDIATELY

PURPOSE FOR COMPLETING FORM ☐ Annual Enrollment ☐ New Employee ☐ Beneficiary Change
☐ Addition of Dependents ☐ Address Change ☐ Name Change _____ ☐ Other _____
Previous Name

PAYROLL DEDUCTION AUTHORIZATION: I authorize a weekly payroll deduction by my employer for health coverage for myself and/or my eligible dependents. Check one of the following boxes to confirm who you will cover: ☐ Employee Only; ☐ Employee + Child(ren); ☐ Employee + Spouse and/or Family ☐ I Decline Coverage Until Next Open Enrollment

***A SPOUSE WHO IS ELIGIBLE FOR COVERAGE THROUGH HIS OR HER OWN EMPLOYER IS DISQUALIFIED FROM COVERAGE UNDER THIS PLAN IF HE OR SHE HAS NOT ELECTED/ACCEPTED SUCH COVERAGE.**

Important Note: If you do not enroll your eligible dependents for coverage at this time, you will not be able to do so until the next annual Open Enrollment. Failure to complete and return this form will cause loss of health plan eligibility.

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX M/F	BIRTHDATE (Month/Day/Year)	RELATIONSHIP TO MEMBER
Member/Employee				Self
Mailing Address (Street, City, State, Zip Code)				
Phone Number		**E-mail Address**		
Spouse* You must check the box above for weekly payroll deduction				**Date of Marriage:**
Dependent Children* You must check the box above for weekly payroll deduction				

OTHER INSURANCE INFORMATION – **YOU MUST COMPLETE THIS SECTION**

1. Are you, your spouse, or other dependents covered by or eligible to enroll in any other group medical insurance plan including Medicare? YES ☐ NO ☐ ***If "YES," please provide the information requested below. If "NO," please go to #3 below.***

_____
Name of Subscriber with Other Coverage **Subscriber Social Security Number**

_____
Name and Address of Other Insurance Company **City** **State** **Zip**

_____
Policy or ID Number: If Medicare, copy of Medicare ID must be on file with the Administration Office.

2. Other insurance covers: Employee ☐ Spouse ☐ Children ☐ Date Coverage Began: _____
3. Is your spouse employed? YES ☐ NO ☐ If yes, list employer:_____
4. Does spouse's employer provide access to group health insurance? YES ☐ NO ☐
5. If yes, was that coverage declined? YES ☐ NO ☐ Or accepted? YES ☐ NO ☐

HEALTH & WELFARE/PENSION BENEFICIARY DESIGNATION

If you select an ineligible beneficiary or do not designate a beneficiary, your death benefit(s) will be paid in the order of preference (if any) outlined in the Pension Plan Document or Health and Welfare Plan Document.

Beneficiary Name _____ _____
Last **First** **Social Security Number**

Beneficiary Address _____

Unless otherwise noted, if two or more beneficiaries are named, proceeds shall be paid in equal shares to the above beneficiaries.

I hereby certify that the above information is true, correct and complete to the best of my knowledge and supercedes any beneficiary designation signed prior to the date shown below. I am an eligible participant as a member of the bargaining unit, retiree, or covered by special agreement. I hereby expressly acknowledge that false information given to an employee benefit plan is a crime and a violation of AS 21.36.360.

Date: _____ _____
Participant Signature ***(must be signed by participating employee)***

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