



# WASHINGTON TEAMSTERS WELFARE TRUST

## ANNUAL OPEN ENROLLMENT - 2023

To receive benefits under this Plan and avoid delays in claim administration, you must re-enroll **annually**. You may re-enroll online by registering at [www.nwadmin.com](http://www.nwadmin.com) or by submitting this completed form to the Trust's Administrative Office. When enrolling a **new** dependent you must also submit documentation verifying your dependent's eligibility.

**INSTRUCTIONS:** Complete EACH section front and back. SIGN and DATE. Use INK. PRINT. Data provided will replace all information on file with the Trust Office. For questions, call **1 (800) 458-3053**.

**MAIL TO:** Washington Teamsters Welfare Trust  
2323 Eastlake Avenue East  
Seattle WA 98102-3393

**NOTE:** You may register at [www.nwadmin.com](http://www.nwadmin.com) and make changes to your participant data on-line in lieu of resubmitting this form

**ADMINISTRATIVE  
USE ONLY**

DATE: \_\_\_\_\_  
INITIALS: \_\_\_\_\_

### PARTICIPANT DATA

LAST NAME		FIRST NAME		MIDDLE INITIAL
SOCIAL SECURITY NUMBER		MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	DATE OF BIRTH	
MAILING ADDRESS		CITY, STATE, ZIP	PHONE NUMBER Home <input type="checkbox"/> Cell <input type="checkbox"/>	
MARITAL STATUS				
SINGLE <input type="checkbox"/>	MARRIED <input type="checkbox"/> Date of Marriage: _____		DIVORCED <input type="checkbox"/> Date of Divorce: _____ Widowed <input type="checkbox"/>	
EMPLOYER (COMPANY NAME)		DATE OF HIRE	LOCAL UNION NO.	
EMAIL ADDRESS				

### ELIGIBLE DEPENDENT DATA

Check here if you have no spouse or eligible dependents as described below.

If you do have eligible dependents, complete this section and list ALL your eligible dependents each time you submit this form. Eligible dependents include the following (see plan book for complete details):

1. Your spouse or domestic partner.

NOTES: A. You may enroll a domestic partner **only if** your employer provides domestic partner coverage. If enrolling in the Trust Plan and have not previously enrolled your domestic partner, you must also obtain and attach the Trust's Affidavit of Domestic Partnership and required proof of domestic partnership (refer to affidavit for list of acceptable proof); B. You may elect to not list a spouse only due to death, divorce, or legal separation or if your spouse consents to not being covered (documentation may be required).

2. Your natural or adopted children and step-children under 26 years of age **or** incapable of self-support because of mental or physical incapacities.

3. Your unmarried grandchildren, children for whom you have been appointed guardian by the court, and children of your domestic partner **if your employer provides domestic partner coverage**, who either (a) are under 19 years of age, live with you, and are dependent on **you** for support and maintenance, or (b) meet the conditions of (a) but are either 19 through 25 years of age and also full-time students in an accredited educational institution, or incapable of self-support because of mental or physical incapacities.

**NOTE:** When enrolling a NEW dependent only, the Plan requires all Participants to submit documentation to verify dependency status as described above. Claims submitted on behalf of dependents that have not been verified **will not be paid** until the required documentation has been submitted. **If you have previously verified your dependent's eligibility** you do not need to submit documentation again. Contact the Trust's administrative office if you have questions regarding whether you have previously verified a dependent or what documentation is required. Such documentation may include, but is not limited to:

Spouse – Marriage Certificate	Child – Birth Certificate/Proof of Adoption	Ward – Guardianship Papers
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**If adding a NEW dependent, please submit copies of the required documentation for each dependent along with this form.**

Please read #2 and #3 above before listing children.			DATE OF BIRTH	RELATION	SOCIAL SECURITY NO.	GENDER		DOES CHILD LIVE WITH YOU?	
LAST NAME	FIRST	INITIAL				MALE	FEMALE	YES	NO
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU HAVE ADDITIONAL DEPENDENTS PLEASE ATTACH A SEPARATE SHEET OF PAPER  
PLEASE COMPLETE REVERSE SIDE. PARTICIPANT MUST SIGN AND DATE FORM.



### DEPENDENT CHILDREN OF DIVORCED OR SEPARATED PARENTS

If any dependent(s) added to coverage is covered under another healthcare plan and the natural parents are divorced or separated, Washington State regulations require that the information requested below be completed in full.

NAME OF PARENT WITH CUSTODY (IF PARENTS HAVE JOINT CUSTODY, INDICATE HERE <input type="checkbox"/> )		BIRTH DATE OF OTHER PARENT	
If divorced, did a court establish financial responsibility for the child(ren)'s healthcare?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
If yes, the responsible person(s) are:			
NAME	STREET ADDRESS OR PO BOX	CITY, STATE, ZIP	PHONE NUMBER

### OTHER INSURANCE DATA

THIS FORM WILL BE RETURNED IF THIS SECTION IS NOT **COMPLETED IN FULL**, WHICH WILL DELAY THE ENROLLMENT PROCESS.

Check here if you and your dependents have no other insurance.

If you or any of your dependents have or had coverage with any other healthcare plan in the last 12 months (coverage through an insurance company, a self-insured plan, a group retiree medical plan, including MEDICARE) or this Trust, please complete this section.

	Policy No. 1	Policy No. 2	Policy No. 3
Type of Healthcare Coverage (check all that apply)	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other
Name of Insured Person			
SSN of Insured Person			
Name(s) of Dependent(s) covered under this insurance			
Insured's Relationship to Dependent(s)			
Name of Insured Person's Employer			
Name of Insurance Company			
Street Address or PO Box			
City			
State, Zip Code			
Insurance Company Phone No.			
Group or Policy Number			
Effective Date of Coverage			
Termination Date of Coverage, if not Active			

### CHOOSE A MEDICAL PLAN FOR 2023

**NOTE: YOU MUST COMPLETE ALL SECTIONS OF THIS FORM NOT JUST YOUR PLAN SELECTION BELOW.**

- I do NOT want to change medical plans in 2023. I want to keep my current plan.
- I want to change my medical plan for 2023 to:
- Washington Teamsters Welfare Trust Medical Plan (Premera PPO Plan)
  - Kaiser Permanente Medical Plan

**REGARDLESS OF WHICH PLAN YOU CHOOSE PLEASE MAIL THIS FORM TO THE TRUST OFFICE AT:  
Washington Teamsters Welfare Trust - Attn: Annual Enrollment - 2323 Eastlake Ave E - Seattle WA 98102**

**FAILURE TO FILE OR UPDATE YOUR PARTICIPANT DATA OR SUBMIT THE REQUIRED DEPENDENT VERIFICATION DOCUMENTATION WITH THE ADMINISTRATIVE OFFICE MAY DELAY THE PROCESSING OF YOUR CLAIMS**

It is a crime to knowingly provide false, incomplete, or misleading information to the Trust Administrative Office for the purpose of defrauding the Trust. Penalties include imprisonment, repayment of all claims paid inappropriately, fines, and denial of insurance benefits. With my signature, I hereby certify that the information provided on this Participant Data Form is true and correct and I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to the Washington Teamsters Welfare Trust or its designated agent.

x \_\_\_\_\_  
PARTICIPANT'S SIGNATURE

\_\_\_\_\_  
DATE SIGNED