CEMENT MASONS AND PLASTERERS TRUST FUNDS

PLEASE PRINT

ENROLLMENT FORM

F16

State: AK ☐ or WA ☐ Local No_____

IMPORTANT: Please complete this form in its entirety, **listing all eligible dependents** (spouse and/or children) and current beneficiary. **This form will replace any other enrollment/beneficiary form on file at the Administration Office.** It is necessary to provide copies of documentation such as a marriage certificate, birth certificate, adoption decree, legal guardianship, and/or parenting plan if applicable. If removing a spouse, provide a copy of the divorce decree, decree of legal separation or death certificate. **NOTE:** additional documents may be requested by the Administration Office. **Due to ACA/IRS reporting requirements, you must provide you and your dependent's Social Security Numbers, if you do not provide, this form will be returned to you.**

☐ New Enrollment ☐ Address Change # ☐ Name Change _____ ☐ Change/Add Dependent(s)
previous name

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX (M/F)	BIRTHDATE (Mo/Day/Year)	RELATIONSHIP to SUBSCRIBER	Check if Step, Foster or Adopted Child
Member				**Self**	
Mailing Address (Street or PO Box, City, State, Zip Code)					
Telephone Number		**Email Address**			
Spouse				Date of Marriage	
Eligible Dependents (see back for definition)					

1. Are you, your spouse, or other dependents enrolled in or eligible to enroll in any other group medical, dental or vision plan including Medicare? ☐ Yes ☐ No If "yes", please provide the information below. If enrolled in Medicare Parts A, B, or D, a copy of your Medicare ID card must be on file with the Administration Office.

Name of Subscriber with Other Coverage _____ Soc. Sec. Number _____ Policy or I.D. Number _____

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

2. Insurance Covers: ☐ Subscriber ☐ Spouse ☐ Children 3. Other Coverage Includes: ☐ Medical ☐ Dental ☐ Vision

☐ Beneficiary Change

BENEFICIARY DESIGNATION

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.

HEALTH & SECURITY PLAN

Beneficiary Name _____ _____
(Last) *(First)* *(Relationship)*

Beneficiary Address _____ _____
(Street) *(City)* *(State)* *(Zip)* *(Soc. Sec. No.)*

PENSION PLAN – Death Benefit (complete only if applicable - not available for Local 72 members)

Beneficiary Name _____ _____
(Last) *(First)* *(Relationship)*

Beneficiary Address _____ _____
(Street) *(City)* *(State)* *(Zip)* *(Soc. Sec. No.)*

401(K) PLAN

Beneficiary Name _____ _____
(Last) *(First)* *(Relationship)*

Beneficiary Address _____ _____
(Street) *(City)* *(State)* *(Zip)* *(Soc. Sec. No.)*

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.

_____ Date _____

Signature *(must be signed by participating member)*

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

NOTICE

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

Completion of this Enrollment/Change Form does not constitute a guarantee of benefits. Actual benefits are based on eligibility and Plan provisions in effect at the time of service. Please refer to your Summary Plan Description for eligibility rules and a complete list of benefits.

The Board of Trustees reserves the right to request any and all documents to verify the status of the Eligible Dependents.

Please note, in order for the Trust's dental and vision plans to be considered excepted benefits for the purposes of federal law, the Trust is required to provide you with the option of opting out of the Trust's dental and vision benefit plans. Electing to opt out of the Trust's dental and vision plans will not change your dollar bank deduction rate or the contributions required to obtain Trust coverage. If you nonetheless want to opt out of the Trust's dental and vision plans please send a request in writing to the Trust Administration Office at the address provided on your enrollment form.

DEFINITION OF DEPENDENT ELIGIBILITY

Your Eligible Dependents include:

1. Your lawfully married spouse; and
2. Your Eligible Dependent Children. Eligible Dependent Children include your natural children, your adopted children, your stepchildren or children placed with you for adoption who are under the age of 26. In addition, Eligible Dependent Children include a legally placed foster child who is placed with the participant by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Eligible Dependent Children also include children, other than those mentioned above, for whom you have legal custody or are the legal guardian pursuant to a judgment, decree, or other order of any court of competent jurisdiction and provided they depend upon you for support and live with you in a regular parent-child relationship.
3. In accordance with federal law, the Plan also provides coverage for certain dependent children (called alternate recipients) if directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction.
4. Your unmarried, developmentally disabled and physically handicapped dependent child may continue coverage after reaching age 26 if the child is solely dependent upon you for support, not capable of self-sustaining employment by reason of developmental disability or physical handicap and provided the dependent was an Eligible Dependent Child and so handicapped at the time of reaching the limiting age of 26. You must submit written proof of such incapacity to the Trust Administration Office within 31 days of the child's attainment of age 26. The Trust Administration Office, upon receipt of the proof, has the right to have a Physician it designates examine the child as it may reasonably require, but not more often than once every two years. Eligibility for disabled or handicapped dependent children will end when the disability no longer exists, or when you fail to submit any required evidence of disability as requested by the Trust Administration Office.

The following are not considered Eligible Dependents:

1. Your legally separated or divorced spouse;
2. A child who has been legally adopted by another person. Eligibility ends on the date the adoptive parents assume custody.
3 A child who has attained the maximum limiting age. The maximum limiting age is the child's 26th birthday.