



EMPLOYEE PAINTERS' TRUST

ENROLLMENT FORM

Event Date: _____

Effective Date: _____

CHECK ALL THAT APPLY:

New Enrollment Add Dependent Remove Dependent Plan Change Address Change

EMPLOYEE'S FULL LEGAL NAME: _____ SSN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ GENDER: (Circle One) Male Female

DATE OF BIRTH: _____ PHONE NUMBER: (____) _____ EMAIL: _____

MARITAL STATUS: Married (Date of Marriage) _____ Single Divorced (Date of Divorce) _____

EMPLOYER _____ DATE OF HIRE: _____ LOCAL UNION # _____

<u>MEDICAL PLAN: (Provided By)</u> AETNA	<u>DENTAL PLAN: (Provided By)</u> DELTA DENTAL	<u>VISION PLAN: (Provided By)</u> VISION SERVICE PLAN (VSP)**
** Dental and Vision benefits excluded from Basic Benefits (Western Washington Residential Painting and Utah Drywall)**		

NOTE: IF YOU ARE ADDING ANY DEPENDENTS WHO ARE ON MEDICARE, PLEASE INCLUDE A COPY OF THEIR MEDICARE CARD.

DEPENDENTS - (Including Spouse)

YOU MUST ATTACH LEGAL DOCUMENTATION THAT APPLIES TO ADD YOUR DEPENDENTS:

Birth Certificate(s) for children, Marriage Certificate for spouse, Legal Adoption papers, Legal Guardianship papers

FULL NAME	SSN	GENDER	DATE OF BIRTH	RELATIONSHIP
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I agree to notify the Trust Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of defrauding obtaining plan coverage. Penalties may include imprisonment, fines, and denial of benefits.

EMPLOYEE SIGNATURE _____ DATE _____