PACIFIC COAST SHIPYARDS
METAL TRADES TRUST FUND

MEDICARE RETIREE ENROLLMENT FORM

Date of Hire: _____
Event Date: _____
Effective Date: _____

CHECK ALL THAT APPLY: ☐ **New Enrollment** ☐ **Adding Dependents** ☐ **Plan Change** ☐ **Address Change**

EMPLOYEE'S FULL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ DATE OF BIRTH: _____ EMAIL: _____

PHONE NUMBER: (_____) _____ GENDER: (Mark One) Male _____ Female _____

MEDICAL PLAN: WASHINGTON (CHOOSE ONE):

☐ UNITED HEALTHCARE SENIOR SUPPLEMENT PLAN (**Retiree** Grp# 2650)

☐ KAISER PERMANENTE SENIOR ADVANTAGE PLAN (**Retiree** Grp# 26200)

NOTE: IF YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS ARE ON MEDICARE, PLEASE INCLUDE A COPY OF YOUR MEDICARE CARD.

DEPENDENTS - (Including Spouse)

(**ATTACH LEGAL DOCUMENTATION THAT APPLIES**: birth certificate(s), marriage certificate, adoption papers, guardianship papers)

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SSN	GENDER

I agree to notify the Fund 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 stating false or misleading information or the omission of material information could be grounds for denial of benefits.

MEMBER SIGNATURE _____ **DATE:** _____

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