WESTERN STATES HEALTH & WELFARE TRUST OF THE OPEIU

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Phone (503) 224-0048 or (800) 547-4457, ext. 1678 Fax (503) 228-0149 email westernstates@benesys.com

MEDICAL PLAN DESIRED

- ❑ REGENCE BCBS PPO PLAN
- ❑ KAISER PERMANENTE

☐ **When completing this form, if you require additional space, please attach an additional page. Please check this box if additional pages are attached.**

DENTAL PLAN DESIRED

- ❑ TRUST DENTAL PLAN
- ❑ KAISER PERMANENTE
- ❑ WILLAMETTE DENTAL

Note: Choice of coverage is offered to new employees or during Open Enrollment

I am applying:

☒ For open enrollment

- ☐ To add Spouse **(Also reverse side of form is required)**
- ☐ To add Domestic Partner **(Also reverse side of form and Autopay form are required)**
- ☐ To add child(ren)
- ☐ To remove family member(s)

EMPLOYEE INFORMATION (This section must always be completed when enrolling for the first time or making changes)

Employee Last Name	First Name	MI	Sex F ☐ M ☐	Date of Birth	Local Union #

Social Security #	Email Address	Employer	Hire Date

Mailing Address	City	STATE	ZIP	Phone ☐ Mobile ☐ Home ( )

Marital Status: ☐ Married ☐ Never Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

Date of Marriage: **Date of Divorce or Death of Spouse/Partner:**

Work Phone ( )

DEPENDENT INFORMATION (All information requested must be completed. If any item is not applicable, write "N/A")

Requirements when enrolling dependents: If enrolling a spouse or domestic partner, completion of the reverse side of this form is required, along with a marriage certificate photocopy for spouse, autopay form for domestic partner, and birth-certificate photocopies for children.

Add	Remove	Relationship (Spouse, Domestic Partner, Son, Daughter)	Last Name First Name MI	Gender (M or F)	Social Security#	Date of Birth MM/DD/YY

OTHER CURRENT COVERAGE

Do you or any family members currently have other group (employer) coverage? ☐ Yes ☐ No

Are any dependents eligible (whether or not they are enrolled) for other group (employer) coverage through either their own or a spouse's employment? ☐ Yes ☐ No

If yes, dependent name and date dependent was first eligible for such coverage: _____

Are you or any family members covered by Medicare? ☐ Yes ☐ No

Are you or any family member covered by Medicare disability? ☐ Yes ☐ No

If the answer to any of the above questions is "Yes," please complete the section below.
(If you have more than one additional policy, provide information on a separate sheet.)

Name of Policy holder with other coverage	Relationship

Policy holder's birth date	Name of other group insurance plan

Address of other coverage	City	State	Zip

This coverage is for: ☐ Medical ☐ RX ☐ Dental ☐ Vision	Plan covers: ☐ Self ☐ Spouse ☐ Child(ren) ☐ Stepchild(ren)	Numbers that identify you to other group plan (group, ID, etc.):

Name of Employer:	☐ Continuation ☐ Retiree ☐ Active	Effective Date	Termination Date

NOTE: If you or your dependents become eligible for and/or enrolled in other coverage, you are required to notify the plan in writing within 30 days. Failure to notify the plan of other coverage and/or any false statements or misrepresentation on this form is considered fraudulent and may result in retroactively terminating plan coverage, in which event you will be responsible for reimbursement for all amounts paid in connection with that coverage, including claims incurred.

COVERAGE OF CHILDREN: An employee's child will be considered a dependent until the end of the month that the child attains age 26. The term "child" may include children related to the employee by blood or marriage, such as siblings and grandchildren. In the case of siblings and other relatives who are not natural children, the employee must produce a court order showing legal guardianship to obtain coverage. In the case of grandchildren, the employee must show either legal guardianship or that the grandchild's natural parent is an eligible dependent enrolled in this plan. Coverage for the child can continue beyond age 26 if the child meets the definition of incapacitated child as defined in the benefit booklet.

Note: If enrolling a spouse or domestic partner, it is also required that you and your spouse or domestic partner complete and sign the reverse side of this form.

I certify that I have read the instructions and that the above information is complete and accurate. I also certify that all claims submitted will be only for myself or for my dependents who are eligible for benefits under the plan. I understand that I will be responsible to reimburse the Trust fund for all amounts paid in connection with claims for me or my dependents if I make any false statements or misrepresentation in this form or in any claim form, or if I conceal any information pertaining to any such claims. I agree to provide the Trust Fund, upon request, with verification of any information.

PLEASE SIGN X **Date Signed**

WESTERN STATES HEALTH & WELFARE TRUST FUND OF THE OPEIU

DECLARATION OF MARRIAGE OR DOMESTIC PARTNERSHIP

_____ and I are spouses or domestic partners and meet
(Spouse or Domestic Partner's name)
the requirements set forth below in all respects. For purposes of this declaration, a "*Domestic Partnership*" is one consisting of two persons of the same or opposite gender.

1. We are each 18 years of age or older and are legally married or share a close personal relationship.
2. We are responsible for each other's common welfare and neither of us is married to or in a registered domestic partnership with anyone else.
3. We share a common residence.
4. We are jointly, financially responsible for basic living expenses including, but not limited to, food, shelter, and medical expenses.
5. We are not related by blood closer than would bar legal marriage in any state where we have a common residence and are domiciled.
6. We were mentally competent to consent to contract when our marriage or domestic partnership began and remain mentally competent.
7. We agree that we are bound by and subject to all the provisions of the health plan and any additional provisions of the Domestic Partnership Endorsement if applicable.
8. We understand that willful falsification of information contained in this affidavit may result in the termination of our enrollment in the health plan and could result in a claim for damages for losses sustained by the health plan because of such willful falsification.
9. We agree to notify the Trust Office in writing within 30 days of any change that would cause us to fail to meet any requirement of this declaration, the underlying health plan, or the Domestic Partnership Endorsement if applicable.

10. We certify under penalty of perjury under the laws of the State of _____, where this declaration is executed,
(State of residence)
that the foregoing is true and accurate to the best of our knowledge.

This declaration terminates upon the death of the signing employee's spouse or domestic partner, or by a change in circumstances attested to in this declaration. The signing employee must notify the Trust Office in writing within thirty (30) days after such death or change.

Notice: Signing this declaration may or may not have legal implications affecting relations between married or domestic partners beyond the extension of medical or dental insurance coverage for which it is intended. If you desire further information concerning the possible legal consequences of signing this form, please consult an attorney. There may also be tax consequences that you should review with your tax advisor.

I attest that the certification I have provided herein is true and correct to the best of my knowledge.

Employee's signature	**Spouse or Domestic Partner's signature**
Date and Place	**Date and Place**