OREGON-WASHINGTON CARPENTERS-EMPLOYERS HEALTH AND WELFARE TRUST FUND

Enrollment/Beneficiary Designation Form

All parts of the enrollment form must be completed

SECTION I ENROLLMENT

Participant Information

Last Name	First Name	M.I.	Social Security Number
Street Address	City	State	Zip Code
Phone Number with Area Code	Local Union Number	Date of Birth:	
Choose One:	☐ Carpenters Trust Health and Dental Plan ☐ Kaiser Health and Carpenters Trust Dental – Have you ever been a member of Kaiser? ☐ Yes ☐ No		

Is this form for: ☐ New Enrollment ☐ Update of Information On File

Dependent Information Eligible dependents include your legal spouse, domestic partner, and unmarried children under age 19 or who are "students."‡ "Children" are your natural children, other children related to you by blood or marriage, stepchildren, adopted and foster children, children placed for adoption or foster care, and children of your domestic partner (if your domestic partner is enrolled for coverage). To enroll any dependent for coverage, you must complete this form and provide proof of eligibility (for example, a certificate of marriage, domestic partnership, or birth).

List All Dependents To Be Covered	Date of Birth	Sex	Social Security Number	Student‡	Covered By Any Other Medical or Dental Plan?*	
Spouse or Domestic Partner†		☐M ☐F		☐ Yes ☐ No	☐ Yes ☐ No	Date of Marriage/ Dom. Partnership
Child		☐M ☐F		☐ Yes ☐ No	☐ Yes ☐ No	Stepchild ☐ Child of Domestic Partner† ☐
Child		☐M ☐F		☐ Yes ☐ No	☐ Yes ☐ No	Stepchild ☐ Child of Domestic Partner† ☐
Child		☐M ☐F		☐ Yes ☐ No	☐ Yes ☐ No	Stepchild ☐ Child of Domestic Partner† ☐
Child		☐M ☐F		☐ Yes ☐ No	☐ Yes ☐ No	Stepchild ☐ Child of Domestic Partner† ☐

‡ A "student" is a Child who is age 19 through 24 and enrolled in a secondary school or an accredited school (which does not include any school that offers courses only through the Internet) for 12 or more credit hours per quarter or semester. Please give the Trust Office a copy of the qualifying student's class schedule with this form. If the student's serious injury or illness causes a medically necessary leave of absence from school or other change in enrollment, he or she may continue to be covered as a dependent until the earlier of : (a) a year from the date the leave begins or the enrollment is changed and (b) loss of eligibility that is not related to his or her student status (e.g., your coverage ends).

* If you or your dependents are covered by another medical or dental plan, please provide a copy of the insurance card(s).

† Coverage of Your Domestic Partner and Children of Your Domestic Partner:

For my domestic partner or the child of my domestic partner to be my federal tax dependent, he or she must receive over half of his or her support from me; have my home as his or her principal residence and be a member of my household; be a U.S. citizen, U.S. national, or legal resident of the U.S., Mexico, or Canada; not have a relationship with me that violates local law; and not be a "qualifying child" of any other taxpayer (i.e., a taxpayer's child, sibling, or descendant of a child or sibling who meets certain residency, age, and support requirements) during the taxable year.

I hereby certify that my domestic partner ☐ **is** / ☐ **is not** my dependent for federal income tax purposes.

I hereby certify that _____(child of my domestic partner) ☐ **is** / ☐ **is not** my dependent for federal income tax purposes.

I hereby certify that _____(child of my domestic partner) ☐ **is** / ☐ **is not** my dependent for federal income tax purposes.

I hereby certify that _____(child of my domestic partner) ☐ **is** / ☐ **is not** my dependent for federal income tax purposes.

I understand that the value of Trust coverage provided to my eligible dependents who are not my federal tax dependents will be imputed income to me. **I understand that for my non-federal tax dependent to begin and continue to be covered by the Trust, I must pay the Trust, in advance of the coverage month as required by the Board of Trustees, the applicable withholding and employee-payable payroll tax amounts.** The withholding will be deposited with the federal or state revenue departments and is a credit against my income tax.

I will notify the Trust Office in writing if, at any time, my enrolled domestic partner or his or her child ceases to be my dependent under the Trust or federal income tax rules.

SECTION II BENEFICIARY DESIGNATION

Name of Beneficiary – Health and Welfare	Social Security Number		Birth Date
Street Address	City	State	Zip

This beneficiary designation supersedes all previous designations, but I understand that if I designate a different beneficiary on a form supplied by an insurance company providing Trust life insurance or accidental death and dismemberment benefits either before or after completing this form, then the beneficiary designation on the insurance company's form will control.

I hereby apply for Carpenters Trust Health and Dental Plan benefits or Kaiser Health with Carpenters Trust Dental benefits. If Kaiser Health is elected, I understand that I must complete a Kaiser enrollment form. I understand that my coverage is not effective until the first day of the second calendar month after I have met the Plan hours requirements and that my dependents' coverage may be effective later.

I agree that, to the best of my knowledge and belief, all statements and answers to the questions in this enrollment/beneficiary designation form are complete and true and agree that they will be the basis of any benefit coverage. The benefits applied for shall become effective in accordance with the Plan terms.

SIGNATURE OF APPLICANT_____ DATE SIGNED _____