OREGON TEAMSTER EMPLOYERS TRUST

PO BOX 4148, PORTLAND, OREGON 97208
PHONE (503) 460-5212 or (877) 396-4612 FAX (503) 284-9386 www.wcearhart.com

☐ New TR 12 FOR OFFICE USE ONLY
ET _____
EFF _____

PLEASE PRINT

EMPLOYEE NAME: _____
LAST NAME, FIRST NAME, MIDDLE INITIAL

SOCIAL SECURITY NUMBER: ___-___-____ M ☐ F ☐ BIRTHDATE: __-__-____

MAILING ADDRESS: _____

CITY: _____ STATE: ____ ZIP CODE: _____-____

☐ HOME PHONE
☐ CELL PHONE NUMBER: ___-___-____ COUNTY: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ LOCAL NUMBER: ____

I AM SUBMITTING THIS:
☐ Open Enrollment (DECEMBER ONLY)
☐ TO UPDATE INFORMATION ☐ AS A NEW PARTICIPANT ☐ TO ADD FAMILY MEMBERS
☐ TO DELETE FAMILY MEMBERS, IF DELETION IS DUE TO DIVORCE GIVE DATE DIVORCE (DECREE) FINAL

DATE OF DIVORCE (DECREE REQUIRED)_____

LIST FAMILY MEMBERS DELETED _____

CHOOSE ONE MEDICAL PLAN ☐ TRUST PLAN (Administered by Regence BlueCross Blue Shield) ☐ KAISER HEALTH PLAN (Must live in Kaiser Service Area)

CHOOSE ONE DENTAL PLAN: ☐ TRUST PLAN PPO ☐ WILLAMETTE DENTACARE ☐ KAISER DENTAL (Must live in Kaiser Service Area)

ARE YOU MARRIED? ☐ YES ☐ NO IF YES, PLEASE GIVE DATE OF MARRIAGE:_____ (MARRIAGE CERTIFICATE REQUIRED)

ARE YOU OR ANY OF YOUR FAMILY MEMBERS ELIGIBLE FOR MEDICARE?
SELF MEDICARE ELIGIBLE: ☐ YES ☐ NO SPOUSE MEDICARE ELIGIBLE: ☐ YES ☐ NO CHILD/CHILDREN MEDICARE ELIGIBLE ☐ YES ☐ NO

To enroll any dependents for coverage, the Trust requires proof of documentation for dependent verification (for example, a certificate of marriage or birth).

SPOUSE NAME: _____
LAST NAME, FIRST NAME, MIDDLE INITIAL

SOCIAL SECURITY NUMBER: ___-___-____ BIRTHDATE: __-__-____ M ☐ F ☐

SPOUSE HAS PRIMARY PRESCRIPTION COVERAGE UNDER ANOTHER PLAN ☐ YES ☐ NO

LIST ALL ELIGIBLE CHILDREN (BIRTH CERTIFICATE REQUIRED)

1. NAME: _____ CHECK IF STEPCHILD: ☐
LAST NAME, FIRST NAME, MIDDLE INITIAL
SOCIAL SECURITY NUMBER: ___-___-____ BIRTHDATE: __-__-____ SEX: M ☐ F ☐

2. NAME: _____ CHECK IF STEPCHILD: ☐
LAST NAME, FIRST NAME, MIDDLE INITIAL
SOCIAL SECURITY NUMBER: ___-___-____ BIRTHDATE: __-__-____ SEX: M ☐ F ☐

3. NAME: _____ CHECK IF STEPCHILD: ☐
LAST NAME, FIRST NAME, MIDDLE INITIAL
SOCIAL SECURITY NUMBER: ___-___-____ BIRTHDATE: __-__-____ SEX: M ☐ F ☐

4. NAME: _____ CHECK IF STEPCHILD: ☐
LAST NAME, FIRST NAME, MIDDLE INITIAL
SOCIAL SECURITY NUMBER: ___-___-____ BIRTHDATE: __-__-____ SEX: M ☐ F ☐

5. NAME: _____ CHECK IF STEPCHILD: ☐
LAST NAME, FIRST NAME, MIDDLE INITIAL
SOCIAL SECURITY NUMBER: ___-___-____ BIRTHDATE: __-__-____ SEX: M ☐ F ☐

LIFE INSURANCE BENEFICIARY INFORMATION

1. PRIMARY BENEFICIARY: _____

RELATIONSHIP TO MEMBER: _____

2. CONTINGENT BENEFICIARY: _____

RELATIONSHIP TO MEMBER: _____

I HEREBY APPLY FOR MYSELF AND FAMILY FOR THE BENEFITS ISSUED BY THIS TRUST AND ANY ENDORSEMENTS THERETO, AND AGREE THAT THE SELECTION OF CARRIER IS BINDING UNLESS CHANGED IN WRITING AT THE NEXT ENROLLMENT PERIOD.

1,000 8/18

EMPLOYEE SIGNATURE: _____ DATE: __-__-____