NORTHWEST AND ALASKA IRONWORKERS TRUST FUNDS

PLEASE PRINT

ENROLLMENT FORM/BENEFICIARY DESIGNATION FORM

F15

Local Union Number _____ ☐ **New Member** ☐ **Address Change** ☐ **Change/Add Dependent(s)** ☐ **Change Beneficiary**

If adding a spouse or a child you must provide a copy of the Birth and/or Marriage Certificate. If removing a spouse, provide a copy of your divorce decree.

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX	BIRTHDATE (Mo/Day/Year)	RELATIONSHIP to SUBSCRIBER	Check if Step, Foster or Adopted Child
Member				**Self**	
Mailing Address (Street or PO Box, City, State, Zip Code)					**Phone Number** ( )
Spouse				**Date of Marriage**	
Eligible Dependents (see back for definition)					

1. Are you, your spouse, or other dependents covered by any other group medical, dental or vision plan including Medicare? ☐ Yes ☐ No If "yes", please provide the information below. If covered by Medicare, a copy of your Medicare ID card must be on file with the Administration Office. List additional coverages on reverse of form.

Name of Person with Other Coverage _____ Soc. Sec. Number _____ Policy or I.D. Number _____

Name and Address of other Insurance Company _____ City _____ State _____ Zip _____

2. Insurance Covers: ☐ Subscriber ☐ Spouse ☐ Children 3. Coverage includes: ☐ Medical ☐ Dental ☐ Vision

BENEFICIARY DESIGNATION - You may name anyone as your Beneficiary to receive benefits from the Trust funds. However, if you have been legally married for one year as of your date of death, your surviving spouse will receive any Retirement and/or Annuity benefits payable. In community property states (Washington, Idaho), your surviving spouse is also entitled to any community property interest in the Vacation and/or Health and Security benefits. **You must indicate your choice of beneficiary below even if you are married and intend for your benefits to be paid to your spouse.**

ALASKA RETIREMENT PLAN – Death Benefit

Beneficiary Name: _____ *Last* *First*

Beneficiary Address: _____ *Street or PO Box*

_____ *City, State, Zip*

NORTHWEST RETIREMENT PLAN – Death Benefit

Beneficiary Name: _____ *Last* *First*

Beneficiary Address: _____ *Street or PO Box*

_____ *City, State, Zip*

NORTHWEST/ALASKA ANNUITY PLAN – Death Benefit

Beneficiary Name: _____ *Last* *First*

Beneficiary Address: _____ *Street or PO Box*

_____ *City, State, Zip*

NORTHWEST VACATION PLAN – Death Benefit

Beneficiary Name: _____ *Last* *First*

Beneficiary Address: _____ *Street or PO Box*

_____ *City, State, Zip*

NORTHWEST/ALASKA HEALTH &SECURITY – Life Insurance

Beneficiary Name: _____ *Last* *First*

Beneficiary Address: _____ *Street or PO Box*

_____ *City, State, Zip*

MEMBER SIGNATURE – I hereby certify that the above information is true, correct and complete to the best of my knowledge and supersedes any beneficiary designation signed prior to the date shown below.

_____

Participant Signature *(must be signed by participating member)*

Date: _____

RETURN A COPY TO THE ADMINSTRATION OFFICE: P.O. BOX 34203 – SEATTLE, WA 98124-1203
RETAIN A COPY FOR YOUR RECORDS

1511-05/2011

HEALTH AND SECURITY PLAN
DEFINITION OF ELIGIBLE DEPENDENT

Your eligible dependents are covered whenever you are covered. Eligible dependents are your:

- Spouse (including your legally separated spouse).
- Son, daughter, stepchild, adopted child, child placed with you for adoption, who is under the age of 26.
  Note: dependent children who have health plan coverage available through their own employer, or their spouse's employer, regardless of whether they enroll in that coverage, are not considered eligible dependents.

Refer to your Plan booklet for more detailed dependent eligibility information.

List additional separate coverage below:

Name of Person with Other Coverage | Soc. Sec. No. | Policy or I.D. Number

Name and Address of other Insurance Company | City | State | Zip

Insurance covers: ☐ Subscriber ☐ Spouse ☐ Children | 3. Coverage includes: ☐ Medical ☐ Dental ☐ Visiou

Name of Person with Other Coverage | Soc. Sec. No. | Policy or I.D. Number

Name and Address of other Insurance Company | City | State | Zip

Insurance covers: ☐ Subscriber ☐ Spouse ☐ Children | 3. Coverage includes: ☐ Medical ☐ Dental ☐ Vision