ALASKA LABORERS TRUST FUNDS

PLEASE PRINT **ENROLLMENT FORM** LOCAL NO. _____

A COMPLETED ENROLLMENT FORM MUST BE ON FILE IN THE ADMINISTRATION OFFICE FOR YOU AND YOUR DEPENDENTS BEFORE ANY CLAIMS CAN BE PROCESSED. ***It is necessary to attach copies of your marriage certificate to enroll your spouse, and birth certificates for any children you wish to cover.*** **SEE THE REVERSE SIDE OF FORM FOR DEFINITION OF ELIGIBLE DEPENDENTS.**

☐ New Member ☐ Name Change_____ ☐ Address Change ☐ Change Dependent(s) ☐ Beneficiary Change
(previous name)

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	SEX	BIRTHDATE (Mo/Day/Year)	RELATIONSHIP to SUBSCRIBER	Check if Step or Foster
Member				Self	
Mailing Address (Street or PO Box, City, State, Zip Code)					
Phone Number	**Email Address**				
Spouse (attach copy of marriage certificate)				Spouse	
Eligible Dependents (attach copies of birth certificates)					

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 requested. If Medicare, copy of Medicare ID card must be on file with the Administration Office.

Name of Subscriber with Other Coverage Soc. Security No. 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

If you select an ineligible beneficiary or do not designate a beneficiary, your death benefit(s) will be paid in the order of preference outlined in the Retirement Plan booklet or the Health and Security Plan policy.

HEALTH AND SECURITY PLAN (You may select anyone.)

Beneficiary _____ Relationship _____

Address: _____ Social Security No. _____

Phone Number: _____ Email Address: _____

PENSION PLAN - DEATH BENEFIT - SURVIVING SPOUSE

"The Alaska Laborers-Employers Retirement Plan requires that, upon your death, your vested retirement benefit shall be paid to your surviving spouse. If you do not designate your spouse as your beneficiary and she/he is still alive at the time of your death, she/he may have a right to some of your benefits depending upon the laws in the state in which you live." If not married, indicate your beneficiary (You may select anyone.)

Beneficiary _____ Relationship _____

Address: _____ Social Security No. _____

Phone Number: _____ Email Address: _____

I hereby certify that the above information is true, correct and complete to the best of my knowledge. **ATTACHED ARE TRUE COPIES OF OUR APPROPRIATE MARRIAGE CERTIFICATES, BIRTH CERTIFICATES, COURT-APPROVED ADOPTION OR LEGAL GUARDIANSHIP DOCUMENTATION.** The above information will be used to determine eligibility for claim/benefit purposes. I am aware of the following, "A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information is guilty of a felony." (Alaska Insurance Code Section 21.36.380)

_____ _____

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

RETURN ONE COPY TO THE ADMINISTRATION OFFICE: P.O. BOX 34203, SEATTLE, WA 98124
OR SCAN AND EMAIL TO: ENROLLMENT@WPAS-INC.COM OR FAX TO: 206-505-WPAS (9727)
RETURN ONE COPY TO THE UNION AND RETAIN ONE COPY FOR YOUR RECORDS

NOTICE

Please be advised that this form MUST be signed by the participating Member for beneficiary designations to be valid.

DEFINITION OF DEPENDENT ELIGIBILITY

Dependent eligibility is determined by your hours worked. Check with the Administration Office if you have questions on eligibility.

Your eligible dependents are your lawful spouse (unless legally separated) and any child under age twenty-six (26). The eligible dependent child must also meet one of the following criteria:

1. A covered participant's natural child as shown on the birth certificate.

2. Legally adopted child:

   A minor child placed with you for the purpose of legal adoption will be covered from the moment the child is placed in your custody.

   The child's coverage will continue until the earlier of:

   - the day the child is removed from your custody prior to legal adoption; or

   - the day coverage would otherwise end in accordance with the Plan provisions.

3. A child for whom the participant has a court order establishing a legal obligation for coverage.

4. A natural or adopted child of the spouse of a covered participant.