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 dependent you must provide a copy of the birth, marriage certificate or other proof of dependency. If removing a spouse, provide a copy of your divorce decree or death certificate.

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			**E-mail Address**		
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 WHITE COPY TO THE ADMINSTRATION OFFICE: P.O. BOX 34203 – SEATTLE, WA 98124-1203
RETAIN A COPY FOR YOUR RECORDS

HEALTH AND SECURITY PLAN
DEFINITION OF ELIGIBLE DEPENDENT

Your eligible dependents are covered whenever you are covered. Eligible dependents include 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 □ Vision

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

Please note, in order for the Trust's dental and vision plans to be considered excepted benefits for the purposes of federal law, the Trust is required to provide you with the option of opting out of the Trust's dental and vision benefit plans. Electing to opt out of the Trust's dental and vision plans will not change your hour bank back-out factor or the hours/contributions required to obtain Trust coverage. If you nonetheless want to opt out of the Trust's dental and vision plans, please send a request in writing to the Trust Administration Office at the address provided on your enrollment form.