



**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			
Choose One: <input type="checkbox"/> Carpenters Trust Health and Dental Plan <input type="checkbox"/> Kaiser Health and Carpenters Trust Dental – Have you ever been a member of Kaiser? <input type="checkbox"/> Yes <input type="checkbox"/> No						

Dependent Information (Eligible dependents include your legal spouse, qualifying domestic partner, and unmarried dependent children under age 19 or children from age 19 through 24 who are unmarried dependent students.* "Children" are those in the following categories: (1) your natural children, other children related to you by blood or marriage, stepchildren, adopted children and children placed for adoption, or foster children who either are your dependents for federal income tax purposes, are entitled to coverage under a qualified medical child support order, or do not qualify as your federal income tax dependents but for whom you pay income tax withholding and employee-payable payroll tax amounts due to the Trust in advance of the coverage month as required by the Board of Trustees; or (2) children of your domestic partner who meet the requirements described below.)

List Participant and all Dependents to be Covered	Date of Birth	Sex	Social Security Number	Student*	Covered By Any Other Medical or Dental Plan? **	
Self		<input type="checkbox"/> M <input type="checkbox"/> F				
Spouse or Domestic Partner		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Marriage (if married)
Child		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	Child Category
Child		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	

* A child qualifies as a student if he or she is age 19 through 24 and enrolled in a secondary school or an accredited college or university for 12 or more credit hours per quarter or semester. Please give the Trust Office a copy of the unmarried dependent student's class schedule with this form.

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

Domestic Partner Coverage: ***

I hereby certify that my domestic partner is / is not my dependent for federal income tax purposes. For my domestic partner to be my 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 United States, 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.

If my domestic partner is not my dependent, I understand that I must pay, in advance of the coverage month as required by the Board of Trustees, the tax withholding and employee-payable payroll tax amounts due to the Trust for my domestic partner to be eligible for coverage. The withholding will be deposited with the federal or state revenue departments and is a credit against my income tax.

Coverage of Your Domestic Partner's Children:

I hereby certify that during the taxable year any child of my domestic partner, who I have listed above as a dependent to be covered, receives over half of his or her support from me, has my home as his or her principal place of abode and is a member of my household, is a citizen or national of the United States or a legal resident of the United States, Mexico, or Canada, and does not have a relationship with me that violates local law.

I understand that I must pay, in advance of the coverage month as required by the Board of Trustees, the tax withholding and employee-payable payroll tax amounts due to the Trust for my domestic partner's child to be eligible for coverage. 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 at any time my domestic partner or the children of my domestic partner cease to be my dependents under the Trust or federal income tax rules.

*** Before your domestic partner is entitled to coverage, you and your domestic partner must swear or affirm before a notary public on a domestic partner affidavit form provided by the Trust Office that you are domestic partners and eligibility for coverage must be approved by the Board of Trustees or their designated representatives.

SEE REVERSE

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.

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 benefits either before or after completing this form, then the beneficiary designation on the insurance company's form will control.			

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 _____

Please return this form to the Fund office:

Oregon-Washington Carpenters-Employers Trust Funds
c/o The William C. Earhart Company, Inc.
P.O. Box 4148
Portland, Oregon 97208

Or fax it to (503) 284-9386