PUGET SOUND BENEFITS TRUST
ENROLLMENT AND BENEFICIARY DESIGNATION FORM

PLEASE PRINT **F25**

IMPORTANT: Please complete this form in its entirety, **listing all eligible dependents** (spouse and/or children) you wish to enroll in the Plan and provide a current beneficiary designation. **This form will replace any other enrollment/beneficiary form on file at the Administration Office.**

Purpose For Completing Form: □ New Member □ Add Dependents □ Change Beneficiary □ Address Change
□ Name Change_____
(previous name)

Name (Last, First, Middle Initial)	Social Security Number	Sex	Birthday (Mo/Day/Year)	Relationship to Member	Check if Step, Foster or Adopted Child
Member				Self	
Mailing Address (Street, City, State, Zip Code)					
Telephone Number		**Email Address**			
Spouse*				**Date of Marriage**	
Dependent Children*					

***Important Note:** The Trust Fund requires documentation such as a birth certificate, legal guardianship, and marriage certificate if you are enrolling your spouse and/or children.

OTHER INSURANCE INFORMATION – **YOU MUST COMPLETE THIS SECTION**

1. Are you, your spouse, or other dependents covered by or eligible to enroll in any other group medical insurance plan including Medicare? ☐ Yes ☐ No If "yes", please provide the information below.

If covered by Medicare, please attached a copy of your Medicare ID card when returning this form to the Administration Office.

Name of Insured with Other Coverage SS# or ID# Policy or Group Number Phone Number

Name and Address of other Insurance Company City State Zip

2. Other Insurance Covers: ☐ Member ☐ Spouse ☐ Children 3. Other Coverage Includes: ☐ Medical ☐ Dental ☐ Vision
4. Is your spouse employed? ☐ Yes ☐ No If yes, list employer: _____
5. If your spouse is employed, does your spouse's employer provide access to health insurance? ☐ Yes ☐ No
6. If yes, did your spouse enroll in the employer health insurance? ☐ Yes ☐ No
7. If no, please state the reason for declining other insurance? _____

BENEFICIARY DESIGNATION

You may name anyone as your Beneficiary to receive benefits from the Trust. However, in community property states, your surviving spouse is entitled to any community property interest in your benefits.

Beneficiary Name_____ _____ _____
(Last) (First) (Social Security Number)

Beneficiary Address _____
(Street) (Apt.) (City) (State) (Zip)

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

_____ _____
Signature (*must be signed by participating employee)* Date

RETURN A COPY TO: ADMINISTRATION OFFICE, P.O. BOX 34203, SEATTLE WA, 98124
or Scan and e-mail to: enrollment@wpas-inc.com or Fax to: 206-505-9727
If you have any questions please call 206-441-7574
RETAIN A COPY FOR YOUR RECORDS

DEFINITION OF DEPENDENT ELIGIBILITY

Eligible dependents shall be the employee's lawful spouse and children (including natural children, step-children, foster children, adopted children, and children placed with the employee or spouse for adoption), up to 26 years of age. A child over age 26 who is currently mentally or physically disabled and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining employment as a result of that disability; and dependent chiefly on You and/or Your Spouse for support and maintenance.

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