United Employees Benefit Trust
Non-Profit Provider of Employee Benefits Since 1965

Address: 220 S 27th St, #B, Tacoma WA 98402
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E-mail: staff@unitedemployees.org
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☐ **ENROLLMENT** (Please print. Form must be completed in its entirety, signed and dated)

Failure to complete each section and return this enrollment form within 30 days could delay eligibility for your dependents.

Failure to provide required documents will delay claims being processed until the documentation has been received.

☐ **ENROLLMENT Update** (Please circle reason for update)

Enrolling Spouse (Notification of Marriage) Deleting Spouse (Notification of Legal Separation or Divorce)

Enrolling Child(ren) Change of Address Other: _____

PARTICIPANT

Employer: _____ **Date of Hire:** _____ **Union:** _____

Employee Name (First, Initial, Last) _____

Mailing Address: _____ **City, St, Zip** _____

Home or Cell Phone: _____ **Work Phone:** _____

Email Address: _____

SSN#: _____ **Date of Birth:** _____ ☐ Female ☐ Male

Marital Status: ☐Single ☐Married - Date _____ ☐Widowed ☐Divorced/Legally Separated – Date _____

Are you covered under other health insurance? ☐ Yes ☐ No If yes, please provide this information in Other Insurance section.

DEPENDENT

☐ **I have a spouse and/or eligible dependents to enroll.** ☐ **I do not have a spouse and/or eligible dependents to enroll.**

Social Security numbers are required for enrollment and **Legal documents** are required to verify dependency.

Spouse – Marriage Certificate required If you divorce after beginning coverage in the Trust you are required to notify the Trust and provide a copy of the first and last page of the divorce decree confirming date of divorce. **Domestic partners** are not eligible**.**

Child – Birth Certificate required Additional information may be required if natural parents are divorced or separated. If applicable Proof of Adoption or Legal Guardianship required.

Dependent (First, Initial, Last Name)_____ ☐ Female ☐ Male

Relation:_____ SSN#: _____ Date of Birth: _____

Email: _____ Phone: _____

Does this dependent live with you? ☐ Yes ☐ No *If no, please provide mailing address, email and phone number*

Dependent (First, Initial, Last Name)_____ ☐ Female ☐ Male

Relation:_____ SSN#: _____ Date of Birth: _____

Email: _____ Phone:_____

Does this dependent live with you? ☐ Yes ☐ No *If no, please provide mailing address, email and phone number*

Dependent (First, Initial, Last Name)_____ ☐ Female ☐ Male

Relation:_____ SSN#: _____ Date of Birth: _____

Email: _____ Phone: _____

Does this dependent live with you? ☐ Yes ☐ No *If no, please provide mailing address, email and phone number*

Dependent (First, Initial, Last Name) _____ ☐ Female ☐ Male

Relation: _____ SSN#: _____ Date of Birth: _____

Email: _____ Phone: _____

Does this dependent live with you? ☐ Yes ☐ No *If no, please provide mailing address, email and phone number*

Dependent (First, Initial, Last Name) _____ ☐ Female ☐ Male

Relation: _____ SSN#: _____ Date of Birth: _____

Email: _____ Phone: _____

Does this dependent live with you? ☐ Yes ☐ No *If no, please provide mailing address, email and phone number*

OTHER INSURANCE

Are you or any dependents covered under other health insurance, including Medicare Parts A or B? ☐ **Yes** ☐ **No**

Name of dependent(s) covered under this insurance: _____

Name of Insured: _____ Type of Coverage: ☐Medical ☐Rx ☐Vision ☐Dental ☐Ortho

Name of Insurance Company: _____ Phone Number: _____

Group/Policy#: _____ Plan ID#: _____ Effective Date: _____

If the insured is not enrolled in UEBT; please provide dependents relationship to insured: _____

Name of dependent(s) covered under this insurance: _____

Name of Insured: _____ Type of Coverage: ☐Medical ☐Rx ☐Vision ☐Dental ☐Ortho

Name of Insurance Company: _____ Phone Number: _____

Group/Policy#: _____ Plan ID#: _____ Effective Date: _____

If the insured is not enrolled in UEBT; please provide dependents relationship to insured: _____

LIFE INSURANCE - DESIGNATION OF BENEFICIARY *(Medical Plan Benefit Only)*

I, (employee name) _____, hereby designate as my beneficiary in the event of my death to receive the Employee Life Insurance and Accidental Means Death and Dismemberment Insurance benefits as set forth in the United Employees Benefit Trust Certificate to the individual listed below. If you want to have multiple beneficiaries please attach an additional sheet identifying the beneficiaries and their percentage of your death benefit

Primary Beneficiary	Relationship to Member	Phone Number
Contingent Beneficiary	Relationship to Member	Phone Number

NOTE: This Designation of Beneficiary becomes effective upon receipt by the Trust when properly filled out and executed by the eligible employee and remains in effect until receipt by the Trust of a new Designation of Beneficiary or written notice absence of valid designation by the employee, the Trust Certificate will determine the beneficiary.

VERIFICATION

By my signature below, I am certifying that the information provided is true and correct to the best of my knowledge and belief. I further recognize that I have an obligation to inform the Trust and update the information provided if it changes in the future.

Member's Signature **Date Signed**