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

Address: 220 S 27th St, #B, Tacoma WA 98402
Phone: (253) 474-1214 or (800) 223-2449
Fax: (253) 474-7180
E-mail: elig@unitedemployees.org
Website: www.unitedemployees.org

☐ **ENROLLMENT** (Please print. Form must be completed in its entirety, signed and dated)

- Failure to return this completed enrollment form within 30 days could delay enrollment for your dependents.
- Benefits under the Trust cannot be provided until a completed enrollment form and required documents have been received. If the Enrollment Form or required documents are received 12-months after the effective date of coverage, eligibility will be updated for perspective benefits only.

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

☐ Enrolling Spouse (Notification of Marriage) ☐ Enrolling Child(ren) ☐ Change of Address, phone, email
☐ Deleting Spouse (Notification of Legal Separation or Divorce) ☐ Other: _____

Once enrolled you can register at www.unitedemployees.org to update enrollment and upload documents.

PARTICIPANT

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

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

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

Phone Number: _____ **Email Address**: _____

SSN or UEBT ID#: _____ **Date of Birth:** _____ ☐ Female ☐ Male

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

Are you entitled to Medicare? ☐ Yes – Effective: _____ ☐ Part "A" Effective: _____ ☐ Part "B" Effective: _____

Are you covered under other health insurance ☐ Yes ☐ No *If yes, please provide this information in the Other Insurance section or include a photocopy of the front and back of your insurance identification card.*

Dependent Enrollment ☐ Yes, I have dependents to enroll – complete page 2. ☐ No, I do not have dependents to enroll.

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**

DEPENDENTS **(If you have more than 3 dependent children, please make a copy of this page or attach a separate piece of paper)**

Social Security Number (SSN) is required for enrollment and **Legal documents** are required to verify dependency.

Spouse – Copy of Certified Marriage Certificate required (if county seal is on the back of the certificate, please include that page). 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 – Copy of Certified Birth Certificate required Additional information may be required if natural parents are divorced or separated. If applicable, Proof of Adoption or Legal Guardianship required.

SPOUSE SSN: ______________ Date of Birth: ______________ ☐ Female ☐ Male

Last Name: ______________ First Name: ______________ Middle Initial:______

Phone Number: ______________ Email Address: ______________

Is spouse entitled to Medicare? ☐ Yes – Effective:__________ ☐ Part "A" Effective: __________ ☐ Part "B" Effective: __________

Is spouse covered under other health insurance ☐ Yes ☐ No *If yes, please provide this information in the Other Insurance section*

DEPENDENT SSN: ______________ Date of Birth: ______________ ☐ Female ☐ Male

Last Name: ______________ First Name: ______________ Middle Initial:______

Relation: ______________ Email: ______________ Phone: ______________

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

DEPENDENT SSN: ______________ Date of Birth: ______________ ☐ Female ☐ Male

Last Name: ______________ First Name: ______________ Middle Initial:______

Relation: ______________ Email: ______________ Phone: ______________

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

DEPENDENT SSN: ______________ Date of Birth: ______________ ☐ Female ☐ Male

Last Name: ______________ First Name: ______________ Middle Initial:______

Relation: ______________ Email: ______________ Phone: ______________

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

OTHER INSURANCE

Are any dependents covered under other insurance or Medicare while covered on this plan? ☐ **Yes** ☐ **No**
If yes, please provide this information or include a photocopy of the front and back of the insurance identification card.

Name of individual(s) covered under this insurance: ______________

Name of Insured:______________ Type of Coverage: ☐Medical ☐Rx ☐Vision ☐Dental

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 individual(s) covered under this insurance: ______________

Name of Insured:______________ Type of Coverage: ☐Medical ☐Rx ☐Vision ☐Dental

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: ______________