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INLAND EMPIRE TEAMSTERS TRUST



PARTICIPANT DATA FORM

ALL INFORMATION IS REQUIRED

PARTICIPANT INFORMATION

Name of Participant: _____ **Employer:** _____

Social Security Number: _____ M F **Date of Birth:** _____ **Date of Enrollment or Change:** _____

Type of Enrollment:
 New Enrollment Marriage Divorce Death Birth/Adoption Other (please specify) _____

Legal documentation is required for adding/dropping your spouse/dependents:
 Birth Certificate Marriage Certificate Divorce Decree Adoption Paperwork Recent Federal Tax Return Death Certificate

Address: _____

 (Street address or PO Box Number)

_____ (City, State, ZIP Code)

Telephone:
 Home: (____) _____
 Cell: (____) _____
 Email: _____

SPOUSE AND DEPENDENT INFORMATION

Add	Drop	Relationship to Participant	Last Name	First Name	Middle Initial	Social Security Number	Date of Birth (mo/day/year)	Gender
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/>	<input type="checkbox"/>							<input type="checkbox"/> M <input type="checkbox"/> F

Is any child over the dependent age limit applying for coverage due to disability? No Yes*
 * If yes, complete and attach the Request for Certification of Disabled Dependent form.

Does any dependent have a different mailing address? No Yes → _____
 List Dependent name

_____ Write in Dependent mailing address including City, State and ZIP Code

OTHER COVERAGE INFORMATION

Do you, your spouse and/or your covered dependents have other coverage available for:
Medical: No Yes **Dental:** No Yes **Vision:** No Yes **Prescriptions:** No Yes **Medicare:** No Yes

COVERAGE #1:
 Enrollee's Name: _____ Enrollee's Birth Date: _____ Plan Name: _____
 Plan Phone Number: _____ Effective Date: _____ Termination Date: _____

COVERAGE #2:
 Enrollee's Name: _____ Enrollee's Birth Date: _____ Plan Name: _____
 Plan Phone Number: _____ Effective Date: _____ Termination Date: _____

COVERAGE #3:
 Enrollee's Name: _____ Enrollee's Birth Date: _____ Plan Name: _____
 Plan Phone Number: _____ Effective Date: _____ Termination Date: _____

COVERAGE #4:
 Enrollee's Name: _____ Enrollee's Birth Date: _____ Plan Name: _____
 Plan Phone Number: _____ Effective Date: _____ Termination Date: _____

★ ★ MUST COMPLETE AND SIGN FORM ON REVERSE SIDE ★ ★

BENEFICIARY DESIGNATION FOR LIFE INSURANCE

Beneficiary's Name:

Beneficiary's Address:

Relationship to You:

(Street address or PO Box Number)

(City, State, ZIP Code)

REQUIRED SIGNATURE

I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted.

Sign Here →

Participant's Signature

Print Name

Date

DON'T FORGET TO INCLUDE ANY REQUIRED DOCUMENTATION FOR YOUR SPOUSE/DEPENDENTS!

Marriage Certificate

Birth Certificate

Divorce Decree

Adoption Paperwork

Recent Federal Tax Return

DSHS Paperwork

Death Certificate