APEA-AFT Health and Welfare Trust Enrollment Form

P60A (APEA Employees)

New Enrollment Open Enrollment Declining Coverage (Complete and return the Waiver of Health Coverage Form)

EMPLOYEE INFORMATION

SOCIAL SECURITY NUMBER	EMPLOYEE NAME (Last, First, Middle Initial)	☐ I AM A FULL TIME EMPLOYEE ☐ I AM A PART TIMR RMPLOYRR

MAILING ADDRESS (Street or PO Box, City, State, Zip)

EMPLOYEE DATE OF BIRTH	MARITAL STATUS	SEX	PHONE NUMBER	E-MAIL ADDRESS
	☐ SINGLE ☐ MARRIED	☐ MALE ☐ FEMALE		

DEPENDENT INFORMATION

I WISH TO ENROLL MY DEPENDENTS: ☐ **YES, If yes, list dependents below** ☐ **NO, I waive coverage for my dependents**

PLEASE ENROLL ME IN THE FOLLOWING CATEGORY: ☐ **EMPLOYEE ONLY** ☐ **EMPLOYEE/SPOUSE** ☐ **EMPLOYEE/CHILD(REN)** ☐ **EMPLOYEE/SPOUSE/CHILD(REN)**

In order to cover a spouse or child, documentation of relationship must be on file at the Trust Administrative Office. Please refer to your open enrollment guide for acceptable forms of documentation.

LIST FAMILY MEMBERS TO BE ENROLLED: Should you require additional lines, please use the reverse side of this form.

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	RELATIONSHIP	
SPOUSE				SPOUSE	DATE OF MARRIAGE
CHILD					
CHILD					
CHILD					
CHILD					

OTHER INSURANCE INFROMATION

Are you, your spouse, or other dependents covered by any other group medical insurance plan including Medicare? ☐ **Yes** ☐ **No**
If "yes," please provide the information requested. If Medicare, copy of Medicare ID card must be on file with the Administrative Office. If separate coverage applies to different dependents, please write additional coverage information on reverse of form.

NAME OF SUBSCRIBER WITH OTHER COVERAGE	SOCIAL SECURITY NUMBER	POLICY OR ID #	Other Insurance covers: ☐ Subscriber ☐ Spouse ☐ Children
NAME AND ADDRESS OF OTHER INSURANCE COMPANY			Coverage includes: ☐ Medical ☐ Dental ☐ Vision

ACKNOWLEDGEMENT AND SIGNATURE

I hereby certify that all information on this enrollment form is true and complete, and that I am an eligible participant of the Plan. I UNDERSTAND THAT MISSTATEMENT, OMISSION OF INFORMATION OR FAILURE TO DISCLOSE ANY INFORMATION MAY BE USED AS A BASIS FOR RESCISSION OF COVERAGE FOR ME AND FOR MY DEPENDENTS, AND THAT I WILL BE GUILTY OF INSURANCE FRAUD. I understand that the coverage applied for will not become effective unless and until the required contributions have been paid and the Trust unconditionally approves and accepts the application. I authorize deductions, if any, from any earnings toward the cost of the coverage.

Furthermore, I authorize any licensed physician, medical practitioner, hospital or other medical related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records of information regarding me or my family or our health, to disclose to WPAS any such information. A copy of this authorization shall be as valid as the original.

DATE OF SIGNATURE	SIGNATURE OF EMPLOYEE
	X

RETURN A COPY TO: APEA-AFT Health & Welfare, P.O. BOX 34203, SEATTLE, WA 98124
or Scan and e-mail to: enrollment@wpas-inc.com
RETAIN A COPY FOR YOUR RECORDS