Washington Wholesalers Health and Welfare Fund

BASIC INFORMATION

Member's Name: _____ Social Security No.: _____

Address: _____ Date of Birth: _____

_____

Telephone No. _____

Active or Retired? _____ Date of Retirement: _____

Type of Retirement (Normal, Disability, etc.): _____

Medicare Eligible? _____

DEPENDENT ELIGIBILITY

Are you seeking coverage under the Washington Wholesalers Health and Welfare Fund for any Dependent? ___ Yes ___ No

IF YES, YOU MUST COMPLETE ALL APPLICABLE SECTIONS OF THIS FORM:

SPOUSE

Name: _____ Social Security No.:_____

Date of Marriage: _____

Date of Spouse's Birth: _____

CHILD(REN)

For each child you are seeking to have covered as a Dependent, provide the following information:

Child 1: _____ Social Security No.: _____

Address: _____ Date of Birth: _____

Relationship (specify natural child, step-child, etc): _____

Child 1's Employer Information: _____ Employer Address _____

Employer Phone Number_____

Is child currently enrolled in employer-sponsored medical coverage? Circle: Yes No

Is Child eligible for coverage through Child's own employer or spouse's employer? Circle: Yes No

Child 2: _____ Social Security No.: _____

Address: _____ Date of Birth: _____

Relationship (specify natural child, step-child, etc): _____

Child 2's Employer Information: _____ Employer Address _____

Employer Phone Number_____

Is child currently enrolled in employer-sponsored medical coverage? Circle: Yes No

Is Child eligible for coverage through Child's own employer or spouse's employer? Circle: Yes No

(Please add additional pages if necessary)

YOU MUST ATTACH A COPY OF YOUR PROOF OF MARRIAGE, ALONG WITH EACH CHILD'S BIRTH CERTIFICATE OR PROOF OF LEGAL GUARDIANSHIP. CERTIFICATION OF SCHOOL STATUS ON SCHOOL LETTERHEAD MUST BE PROVIDED FOR STEP-CHILDREN AND CHILDREN UNDER LEGAL GUARDIANSHIP OLDER THAN AGE 18.

MEMBER CERTIFICATION

I hereby certify that:

_____ (Initial Here) I will notify the Fund's Plan Administrator in a timely manner if or when any of my dependents over the age of 18 becomes eligible to participate in his/her own employer-sponsored health care plan, including his/her spouse's employer-sponsored coverage, and I understand that such notification will thereby forfeit such dependent's right to continue coverage under the Plan as my Dependent.

_____ (Initial Here) The information contained in this Form is true and correct and I understand that the Trustees are relying on this information and the representations I have made in this Form to provide my Dependent(s) with coverage under the Plan.

_____ (Initial Here) If I fail to submit this completed form annually or as otherwise required by the Fund, I understand that my Dependent's eligibility for benefits may be terminated.

_____
Signature of Member

Date: _____