Mailing Address: PO Box 8130, Tacoma WA 98419
Street Address: 220 S 27th St, #B, Tacoma WA 98402
Phone: (253) 474-1214 or (800) 223-2449
Fax: (253) 474-7180 E-mail: staff@unitedemployees.org

☐ **ENROLLMENT FORM (**PLEASE PRINT and COMPLETE ALL SECTIONS)

Failure to complete and return this enrollment form within 30 days could delay eligibility for you or your dependents.
List all of your eligible dependents in the spaces provided. Social Security numbers are required for enrollment.

☐ **ENROLLMENT UPDATE** (PLEASE PRINT and COMPLETE APPROPRIATE SECTION)

___Address Change ___Adding Child ___Adding / Deleting Spouse ___Other:

Employer: ________ **Date of Hire:** ________ **Union:** ________

Employee Name (First, Initial, Last) ________

Address: ________ **City, St, Zip** ________

Home or Cell Phone: ________ **Work Phone:** ________

Email Address: ________

SSN#: ________ **Date of Birth:** ________ **Sex:** ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Divorced or Legally Separated (date) ___/___/___ ☐ Widow(er)

Are you covered under other Dental or Vision insurance? ☐ Yes ☐ No If yes, please provide other insurance information:

Name of **Dental** Insurance: ________ Phone Number: ________

Effective Date: ________ Plan ID#: ________ Group Number: ________

Insured's Name: ________ Relationship to insured: ________

Name of **Vision** Insurance: ________ Phone Number: ________

Effective Date: ________ Plan ID#: ________ Group Number: ________

Insured's Name: ________ Relationship to insured: ________

Name of Spouse / Domestic Partner (First, Initial, Last) ________

Date of Marriage (date) ___/___/___ (Please include a copy of your marriage certificate) Domestic Partner coverage must have been negotiated into the collective bargaining agreement which provides for the Employee's participation in the Trust, in order to be considered an eligible dependent.

SSN#: ________ **Date of Birth:** ________ **Sex:** ☐ Female ☐ Male

Spouses / Domestic Partner Employer: ________

Is spouse / domestic partner covered under other health insurance? ☐ Yes ☐ No If yes, please provide other insurance information:

Name of **Dental** Insurance: ________ Phone Number: ________

Effective Date: ________ Plan ID#: ________ Group Number: ________

Name of **Vision** Insurance: ________ Phone Number: ________

Effective Date: ________ Plan ID#: ________ Group Number: ________

RELEASE

I/We hereby authorize my/our physician, hospital, or medical care service provider to provide the United Employee Benefit Trust, its employees, agents, attorney or advisors, (including Innovative Care Management and Premera) all information which they may request regarding my/our physical or mental condition and any treatment therefore, including copies of any medical records, dental records, or x-rays as required to process claims submitted by me/us.

________ ________
Signature of Member Date

________ ________
Signature of Spouse / Domestic Partner (required if spouse is on plan) Date

Signature of Covered Dependents Age 18-26 (required): Date

________ ________

________ ________

________ ________

Name of Child (First, Initial, Last)____________________

SSN#: ____________ Date of Birth: ____________ Sex: ☐ Female ☐ Male

Relationship: ☐ Natural Child ☐ Step-child ☐ Legally Adopted (Please include copy of dependents birth certificate)
☐ Foster Child (Please include copy of appropriate court order) ☐ Other ____________

If applicable, Attach copy of parenting plan and child support order of natural parents, to document who is to provide health insurance and who is the custodial parent.

Does this child live in the home of our subscriber? ☐ Yes ☐ No If no, please provide address of residence

Address: ____________ City, St, Zip ____________

Is child covered under other health insurance? ☐ Yes ☐ No If yes, please provide other insurance information:

Name of **Dental** Insurance: ____________ Phone Number: ____________

Effective Date: ____________ Plan ID#: ____________ Group Number: ____________

Insured's Name: ____________ Relationship to insured: ____________

Name of **Vision** Insurance: ____________ Phone Number: ____________

Effective Date: ____________ Plan ID#: ____________ Group Number: ____________

Insured's Name: ____________ Relationship to insured: ____________

Name of Child (First, Initial, Last)____________________

SSN#: ____________ Date of Birth: ____________ Sex: ☐ Female ☐ Male

Relationship: ☐ Natural Child ☐ Step-child ☐ Legally Adopted (Please include copy of dependents birth certificate)
☐ Foster Child (Please include copy of appropriate court order) ☐ Other ____________

If applicable, Attach copy of parenting plan and child support order of natural parents, to document who is to provide health insurance and who is the custodial parent.

Does this child live in the home of our subscriber? ☐ Yes ☐ No If no, please provide address of residence

Address: ____________ City, St, Zip ____________

Is child covered under other health insurance? ☐ Yes ☐ No If yes, please provide other insurance information:

Name of **Dental** Insurance: ____________ Phone Number: ____________

Effective Date: ____________ Plan ID#: ____________ Group Number: ____________

Insured's Name: ____________ Relationship to insured: ____________

Name of **Vision** Insurance: ____________ Phone Number: ____________

Effective Date: ____________ Plan ID#: ____________ Group Number: ____________

Insured's Name: ____________ Relationship to insured: ____________

Name of Child (First, Initial, Last)____________________

SSN#: ____________ Date of Birth: ____________ Sex: ☐ Female ☐ Male

Relationship: ☐ Natural Child ☐ Step-child ☐ Legally Adopted (Please include copy of dependents birth certificate)
☐ Foster Child (Please include copy of appropriate court order) ☐ Other ____________

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Does this child live in the home of our subscriber? ☐ Yes ☐ No If no, please provide address of residence

Address: ____________ City, St, Zip ____________

Is child covered under other health insurance? ☐ Yes ☐ No If yes, please provide other insurance information:

Name of **Dental** Insurance: ____________ Phone Number: ____________

Effective Date: ____________ Plan ID#: ____________ Group Number: ____________

Insured's Name: ____________ Relationship to insured: ____________

Name of **Vision** Insurance: ____________ Phone Number: ____________

Effective Date: ____________ Plan ID#: ____________ Group Number: ____________

Insured's Name: ____________ Relationship to insured: ____________

If you have additional dependents, please request a second enrollment form or make a photocopy.