

TYPE OR PRINT

# PSEA HEALTH & WELFARE TRUST

GROUP 9000132

P69-02

## ENROLLMENT-BENEFICIARY – RECORD CHANGE FORM COMPLETE, ATTACH PROOF DOCUMENTS AND RETURN IMMEDIATELY

PURPOSE FOR COMPLETING FORM	<input type="checkbox"/> New Employee (See Below)	<input type="checkbox"/> Address Change (See Below)
<input type="checkbox"/> Change Dependents	<input type="checkbox"/> Marriage Date: _____	<input type="checkbox"/> Divorce Date: _____
<input type="checkbox"/> Adoption (Date of Placement: _____)	<input type="checkbox"/> Death Date: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Name Change (Previous Name: _____)		

EMPLOYEE SOCIAL SECURITY NO.:	EMPLOYEE BIRTHDATE: MO. DAY YR.	SEX M <input type="checkbox"/> F <input type="checkbox"/>
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EMPLOYEE NAME: (Last) (First) (Initial)	OCCUPATION/TITLE:
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MAIL ADDRESS:	NAME OF EMPLOYER:
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CITY, STATE ZIP:	DATE EMPLOYED:	CR-WP FORM
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LIST ELIGIBLE DEPENDENTS WHO ARE YOUR SPOUSE, ELIGIBLE DOMESTIC PARTNER,\* AND UNMARRIED DEPENDENT CHILDREN (INCLUDES NATURAL, ADOPTED OR STEP CHILDREN UNDER AGE 23).

**\*Domestic Partner Affidavit must accompany this form.**

**PLEASE LIST ALL ELIGIBLE DEPENDENTS.**

FIRST NAME	INT	LAST NAME (if different)	SOCIAL SECURITY NUMBER <i>(required for dependent claims payment)</i>	RELATIONSHIP (spouse, domestic partner,* child, step child)	SEX	DATE OF BIRTH			D I S A B L E D	CR-WP FORM
						MO	DAY	YEAR		

1. Are you, your spouse, domestic partner,\* or other dependents covered by any other group medical insurance plan?  
YES \_\_\_\_\_ NO \_\_\_\_\_ 2. If "yes," please provide the information requested.

Name of Subscriber with Other Coverage	Sub. Social Security Number
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Name of Other Insurance Company	Eff. Date
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Address of Other Insurance Company
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City, State, Zip	Medicare Part A Eff. Date:	Medicare Part B Eff. Date
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Policy or I.D. Number
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2. Who does this insurance cover?

<input type="checkbox"/> Insured Only	<input type="checkbox"/> Insured and Spouse Only
<input type="checkbox"/> Insured and Child Only	<input type="checkbox"/> Insured and Entire Family

3. What does coverage include?

<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing
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**\*Domestic Partner Affidavit must accompany this form.**

### LIFE INSURANCE BENEFICIARY DESIGNATION:

If you select an ineligible beneficiary or do not designate a beneficiary, your death benefit(s) will be paid in the order of preference (if any) outlined in the Health and Welfare Plan.

Beneficiary Name \_\_\_\_\_  
(Last) (First) (Social Security Number)

Beneficiary Address \_\_\_\_\_

I CERTIFY THAT ALL ABOVE INFORMATION IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND SUPERCEDES ALL PREVIOUS FORMS SUBMITTED.

I AUTHORIZE THE EMPLOYER TO DEDUCT FROM MY EARNINGS THE AMOUNT, IF ANY, FOR THE COVERAGE SELECTED UNDER THIS PLAN.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_  
*(must be signed by participating member)*

RETAIN LAST COPY FOR YOUR RECORDS AND RETURN OTHER COPIES TO:

PSEA HEALTH & WELFARE TRUST  
ADMINISTRATION OFFICE  
P.O. BOX 93870  
ANCHORAGE, AK 99509-3870

PRODUCT SELECTION: (FILLED IN BY TRUST)
HERITAGE PLUS _____
HERITAGE SELECT _____

