United Employees Benefit Trust
Non-Profit Provider of Employee Benefits Since 1965

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☐ **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 Spouse / Notification of Marriage

___ Adding Child ___ Deleting Spouse / Notification of Legal Separation or Divorce

___ Other (please explain) _____

If you are participating under a medical plan with a **composite rate structure**, the plan provides benefits for yourself and your eligible dependents for one premium.

If you are participating under a medical plan with a **tiered rate structure** you will need to indicate your choice of coverage.

Tiered Rate Options: A5 Plan ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

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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 health insurance? ☐ Yes ☐ No If yes, please provide other insurance information:

Name of **Medical** Insurance: _____ Phone Number: _____

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

Insured's Name: _____ Relationship to insured: _____

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: _____

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.

Name of Spouse (First, Initial, Last)____

Date of Marriage (date) ____/____/____ (Please include a copy of your marriage certificate)

Name of Domestic Partner (First, Initial, Last)____

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

Spouse / Domestic Partner Employer: ____

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 ________________

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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Address: ________________________________ City, St, Zip ________________

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)

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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 ________________

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

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

Name of **Medical** Insurance: ______________________ Phone Number: ______________
Effective Date: ______________ Plan ID#: ______________ Group Number: ______________
Name of **Dental** Insurance: ______________________ Phone Number: ______________
Effective Date: ______________ Plan ID#: ______________ Group Number: ______________
Name of **Vision** Insurance: ______________________ Phone Number: ______________
Effective Date: ______________ Plan ID#: ______________ Group Number: ______________

Are any of the **child(ren)** covered under other health insurance? ☐ Yes ☐ No
If yes, please provide other insurance information:

Name of Child(ren) that this insurance covers ______________________
Is this insurance primary, secondary or tertiary payor? ______________________

Name of **Medical** Insurance: ______________________ Phone Number: ______________
Effective Date: ______________ Plan ID#: ______________ Group Number: ______________
Insured's Name: ______________________ Relationship to insured: ______________
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(ren) that this insurance covers ______________________
Is this insurance primary, secondary or tertiary payor? ______________________

Name of **Medical** Insurance: ______________________ Phone Number: ______________
Effective Date: ______________ Plan ID#: ______________ Group Number: ______________
Insured's Name: ______________________ Relationship to insured: ______________
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(ren) that this insurance covers ______________________
Is this insurance primary, secondary or tertiary payor? ______________________

Name of **Medical** Insurance: ______________________ Phone Number: ______________
Effective Date: ______________ Plan ID#: ______________ Group Number: ______________
Insured's Name: ______________________ Relationship to insured: ______________
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 there is additional insurance, please request a second enrollment form or make a photocopy.

UEBT
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LIFE INSURANCE - DESIGNATION OF BENEFICIARY (must be completed)

I, (employee name) _____, hereby designate as my beneficiary in the event of my death to receive the Employee Life Insurance and Accidental Means Death and Dismemberment Insurance benefits as set forth in the United Employees Benefit Trust Certificate to the individual(s) listed below.

Beneficiary Name	Relationship to Member	Share of Benefit
Beneficiary Name	Relationship to Member	Share of Benefit

NOTE: This Designation of Beneficiary becomes effective upon receipt by the Trust when properly filled out and executed by the eligible employee and remains in effect until receipt by the Trust of a new Designation of Beneficiary or written notice absence of valid designation by the employee, the Trust Certificate will determine the beneficiary.

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.

I/We verify that all of the information specified on this enrollment form is accurate and complete.

Signature of Member	Date
Signature of Spouse (required if spouse is on plan)	Date
Signature of Covered Dependents Age 18-26 (required):	Date