THEATRICAL STAGE EMPLOYEES HEALTH & WELFARE TRUST
ENROLLMENT/BENEFICIARY DESIGNATION FORM **F05-02**

INSTRUCTIONS: Please provide all information indicated and sign the form. If you elect dependent coverage, you must make a self-payment by the 20th of the month for the month of coverage. **Complete this form in its entirety, it will replace any other enrollment/beneficiary designation form on file with the Administration Office.** It is necessary to provide copies of documentation such as a marriage certificate, birth certificate, adoption decree, legal guardianship, and/or parenting plan if applicable. If removing a spouse, provide a copy of the divorce decree, decree of legal separation, dissolution or termination of domestic partnership. **NOTE:** additional documents may be requested by the Administration Office. **Due to ACA/IRS reporting requirements, you must provide you and your dependent's Social Security Numbers, if you do not provide, this form will be returned to you.**

PLEASE PRINT OR TYPE

□ New Member □ Add/Delete Dependent(s) □ Beneficiary Change □ Address Change □ Name Change _____
□ Open Enrollment (PREVIOUS NAME)

Choose a Kaiser Permanente Medical Plan. Each Plan includes coverage through Delta Dental of Washington and VSP Vision Care.
□ CORE PLAN – Group #1428400 **OR** □ BUY-UP PLAN/ACCESS PPO – Group #0601500

MEMBER INFORMATION

Name (LAST, FIRST, MI)	**Social Security Number**	**Sex** (M/F)	**Birth Date** (MO/DAY/YR)

Mailing Address (STREET, CITY, STATE, ZIP CODE)

Home Phone Number	**Cell Phone Number**	**E-mail Address**

DEPENDENT COVERAGE ELECTION (see back for definition of dependent)

□ **Yes, I Elect Dependent Coverage.** I am applying for coverage for my dependents listed below and I understand that I must make monthly payments for dependent coverage by the 20th of the month for the month of coverage. All information below is REQUIRED.

SPOUSE AND DEPENDENT(S) INFORMATION

Name (LAST, FIRST, MI)	**Relationship to Member**	**Social Security Number**	**Sex** (M/F)	**Birth Date** (MO/DAY/YR)	**Check if Step, Foster and/or Adopted Child**
SPOUSE/DOMESTIC PARTNER	Date of Marriage		□ Male □ Female		
DEPENDENT CHILDREN			□ Male □ Female		
			□ Male □ Female		
			□ Male □ Female		
			□ Male □ Female		

OTHER INSURANCE COVERAGE

Are you, your spouse and/or dependents covered by any other medical, dental or vision plan, including Medicare? □ Yes □ No
If "Yes," please provide the information requested below. If you are eligible for Medicare a copy of your Medicare card must be on file.

_____
Name of Person with Other Coverage SS# or ID# Policy or Group No. Group Phone No.

_____
Name and Address of Other Insurance Company City State Zip

Other insurance covers: □ Member □ Spouse/Domestic Partner □ Children Other insurance includes: □ Medical □ Dental □ Vision

LIFE INSURANCE BENEFICIARY DESIGNATION

Please designate a beneficiary to whom life/AD&D benefits will be paid.

Primary Beneficiary _____ Relationship _____

Beneficiary Address _____ Beneficiary Social Security # _____

I hereby certify that the above information is true, correct and complete to the best of my knowledge and supersedes any beneficiary designation signed prior to the date shown below.

_____ _____
Signature *(must be signed by participating employee)* Date

RETURN A COPY TO: ADMINISTRATION OFFICE • P.O. BOX 34203 • SEATTLE, WA 98124-1203
OR SCAN AND E-MAIL TO: ENROLLMENT@WPAS-INC.COM

NOTICE: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Carrier Information is listed below.

Kaiser Foundation Health Plan of Washington
Kaiser Foundation Health Plan of Washington Options, Inc.
1300 SW 27th Street
Renton, WA 98057
www.kp.org/wa
888-901-4636

Delta Dental of Washington – Group # 00324
400 Fairview Ave N #800
Seattle, WA 98109
www.deltadentalwa.com
800-554-1907

Sun Life and Health Insurance Company (U.S.) – Life, AD&D and Short Term Disability- Group # 226815
One Sun Life Executive Park
Wellesley Hills, MA 02481
www.sunlife.com/us
800-247-6875

VSP Vision Care
3333 Quality Drive
Rancho Cordova, CA 95670
www.vsp.com
800-877-7195

DEFINITION OF ELIGIBLE DEPENDENT

- The subscriber's legal spouse, or state-registered domestic partner
- Children who are under the age of 26 ("Children" means the children of the subscriber or legal spouse including adopted children, stepchildren, children for whom the subscriber has a qualified court order to provide coverage and any other children for whom the subscriber is the legal guardian) regardless of marital status, student status, or eligibility for coverage under another plan.