PARTICIPANT DATA FORM

INSTRUCTIONS:

- Use BLUE or BLACK INK and PRINT all information.
- Participant must complete this in FULL.
- If you are updating information only, please check here ❑

RETURN COMPLETED FORM TO:
Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, WA 98102-3393
(206) 726-3277 or 1-800-458-3053

PARTICIPANT DATA

______ – ______ – ______ ❑ Male ❑ Female ____________
Social Security Number — Date of Birth

Participant Last Name — First Name — Middle Initial

Address *(Mailing)* — ❑ Single ❑ Married — Date Married

City — State — Zip Code — ❑ Divorced — Date Divorced

Employer (Company Name) — Date of Hire — Union Local No. — Home Phone Number

ELIGIBLE DEPENDENT DATA

DEFINITION OF ELIGIBLE DEPENDENTS *(List eligible dependents below.)*:

- Your spouse.
- Your unmarried children less than 19 years old.
- Your unmarried children, age 19 but under 26 years, attending an accredited educational institution as a full-time student.
- Your unmarried children who were incapable of self-support prior to age 19 because of mental or physical incapacities.

LIST ELIGIBLE DEPENDENTS AS DEFINED ABOVE.

Last	First	Middle Initial	Date of Birth	Relationship to Participant	Social Security No.	Sex	Does dependent reside with participant? If no, complete next section.
					— —	Male ❑ Female ❑	❑ Yes ❑ No
					— —	Male ❑ Female ❑	❑ Yes ❑ No
					— —	Male ❑ Female ❑	❑ Yes ❑ No
					— —	Male ❑ Female ❑	❑ Yes ❑ No

Proof of dependent eligibility may be requested; i.e., birth certificate, guardianship letters, marriage certificate, divorce papers, student letters bearing school seal. Use bottom of reverse side to name additional dependents.

IF DEPENDENT(S) DO NOT RESIDE WITH PARTICIPANT, COMPLETE BELOW

Dependent Name — Name of person with whom dependent resides — Participant's relationship to dependent

Address of the above person (mailing) — City, State, Zip

Dependent Name — Name of person with whom dependent resides — Participant's relationship to dependent

Address of the above person (mailing) — City, State, Zip

Dependent Name — Name of person with whom dependent resides — Participant's relationship to dependent

Address of the above person (mailing) — City, State, Zip

OTHER INSURANCE DATA

If you or any of your dependents have coverage with any other health care plan (coverage through an insurance company, a self-insured plan, a group retiree medical plan, including MEDICARE) or this trust, please complete this section.

Type of Coverage ❑ Medical ❑ Dental ❑ Vision ❑ Other, i.e., Rx, Chiropractic, Mental Health

Dependent Name | Name of Insurance Company | Name of Insured Person

Insurance Company Address | SSN of Insured Person

City, State, Zip Code | Relationship to Dependent

Effective Date of Coverage | Group or Policy Number

Type of Coverage ❑ Medical ❑ Dental ❑ Vision ❑ Other, i.e., Rx, Chiropractic, Mental Health

Dependent Name | Name of Insurance Company | Name of Insured Person

Insurance Company Address | SSN of Insured Person

City, State, Zip Code | Relationship to Dependent

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Type of Coverage ❑ Medical ❑ Dental ❑ Vision ❑ Other, i.e., Rx, Chiropractic, Mental Health

Dependent Name | Name of Insurance Company | Name of Insured Person

Insurance Company Address | SSN of Insured Person

City, State, Zip Code | Relationship to Dependent

Effective Date of Coverage | Group or Policy Number

DEPENDENT CHILDREN OF DIVORCED OR SEPARATED PARENTS

If any dependent(s) added to coverage is covered under another health care plan and the natural parents are divorced or separated, Washington State regulations require that the information requested below be completed in full.

Name or Parent with Custody (if parents have dual custody, indicate) | Birth Date of Other Parent

If divorced, did the court establish financial responsibility for the child(ren)'s health care? ❑ No ❑ Yes, if yes, please specify name and

address of the person with responsibility: ______________________

Name | Address

City | State | Zip Code | Phone Number

ADDITIONAL DEPENDENT DATA

LIST ELIGIBLE DEPENDENTS AS PREVIOUSLY DEFINED

Last	First	Middle Initial	Date of Birth	Relationship to Participant	Social Security No.	Sex	Does dependent reside with participant? If no, complete next section.
					— —	Male ❑ Female ❑	❑ Yes ❑ No
					— —	Male ❑ Female ❑	❑ Yes ❑ No
					— —	Male ❑ Female ❑	❑ Yes ❑ No
					— —	Male ❑ Female ❑	❑ Yes ❑ No

FAILURE TO RETURN A PARTICIPANT DATA FORM TO THE ADMINISTRATIVE OFFICE MAY DELAY THE PROCESSING OF YOUR CLAIMS

With my signature, I hereby certify that the information provided in this Participant Data Form is true and correct. I authorize any person or institution providing care or services, or any organization in possession of insurance benefit information to release any and all information pertaining to the care or benefits provided to me or my dependents to the Trust or its designated agent.

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Participant's Signature | Date Signed

ADMINISTRATIVE USE ONLY

Date: ______________

Initials: ______________