MASONRY WELFARE TRUST FUND
9848 E BURNSIDE
PORTLAND OR 97216
(503) 254-4022
(503) 254-4119 FAX
TOLL FREE 1 800 591-8326

ENROLLMENT CHANGE

Please use this form to change, add, or delete dependents covered under the **Masonry Welfare Trust Fund.**

REASON FOR UPDATE:

☐ **Adding dependents.** List name(s) and birthdates of family members below
Reason for adding dependents:
- ☐ Marriage, date of marriage__________, ***please return copy of marriage certificate.***
- ☐ Newborn, ***please return copy of birth certificate.***
- ☐ Adoption, date of adoption__________, ***please return copy of court papers.***
- ☐ Enrolling adult child dependent age 19-25.

☐ **Deleting dependents.** List names of dependents being deleted below.
Reason for deleting dependents:
- ☐ Divorce, date divorce final__________, ***please return copy of the entire divorce decree.***
- ☐ Legal Separation, date of legal separation_________, ***please return copy of court papers.***
- ☐ Child ceasing to meet eligibility requirements
- ☐ Other, please fully explain____

☐ **Name Change.** Previous Name________________________. Please return copy of legal paperwork for name change. Please list new name below.

Employee Information

Social Security #: ____________________ **Name:**____
(First Name) (MI) (Last Name)

Address:

____
(Street Address or PO Box) (City) (State) (Zip)

Date of Birth:_________________________ **Home Phone #:** (   ) ______________________

Dependent Information: Please list only dependents affected by change

Eligible Dependents include:
- Your lawful spouse (if not legally separated from the employee)
  The term "lawful spouse" means that you can provide written certification appropriate to the state in which you live which deems a person your "lawful spouse".
- Child from birth through age 18
- Child from 19 through 25

Spouse's Last Name	First	MI	Social Security #	Date of Birth	Gender M F		
Dependent's Last Name	First	MI	Social Security #	Date of Birth	Relationship to Employee: Natural child, step child, etc.	Over the age Of 18?**	Gender
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If ANY person listed above has a different last name than the employee, please specify the relationship:

⇒ ⇒ ⇒ ⇒ ⇒ ⇒ ⇒ ⇒ ⇒ ⇒ ⇒ ⇒ **Please complete and Sign Reverse Side**

☐ If you or any of your dependents are eligible for Medicare, please list their name(s):

_____

☐ Do you or your dependents have coverage under another medical or dental Plan? ☐ Yes ☐ No

Name of other plan_____

Phone #_____ Policy #_____

Name of policyholder_____

Persons covered_____

Effective Date of Coverage_____

Child Custody Information If you or your spouse has ever been divorced or legally separated, please indicate who has legal custody of your child(ren) below:

Name of child(ren)	**Who has legal custody** (Father, Mother, Joint*, Other)	**Date Awarded** (*Please send a copy of the court decree)	**Has the parent WITHOUT custody been required by court decree to provide coverage for the dependent children? If YES, list other coverage provided**

I certify that I have read the instructions and that the above information is complete and accurate. I also certify that all claims submitted will be only for myself or for my dependents that are eligible for benefits under the Plan. I understand that I will be responsible to reimburse the Masonry Welfare Trust Fund for all amounts paid in connection with claims for me or my dependents if I make any false statements or misrepresentation in this form or in any claim form or if I conceal any information pertaining to any such claims. I agree to provide the Trust Fund, upon request, with verification of any information.

Employee's Signature_____ **Date Signed**_____