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

ENROLLMENT FORM

A form must be completed upon entering the Trust and within 30 days of a family status change. If an item is not applicable, write N/A. If more space is needed attach a separate statement with the additional information.

Employee Information

Social Security #: _____ **Name:** _____
(First Name) (MI) (Last Name)

Address: _____
(Street Address or PO Box) (City) (State) (Zip)

Date of Birth: _____ **Local # & State:** _____

Employer: _____ **Home Phone #:** ( ) _____

Marital Status

Are you: ☐ Single
☐ Married - Date of marriage* _____
☐ Divorced - Date of divorce* _____
☐ Widowed - Date of spouse's death _____

Please Note: If you are married, you will need to provide a copy of your Marriage Certificate. *Also*: Birth Certificates will be required for dependent children. Please send these documents when you return this form.

*If you checked off married, please return a copy of your Marriage Certificate. If divorced and you have dependent children, please send a copy of the entire Divorce Decree. ***This information is needed before claims can be processed on your eligible dependents.***

Dependent Information

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".
• Unmarried child from birth through age 25

Spouse's Last Name	First	MI	Social Security #	Date of Birth	Sex 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? Yes NO	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? Yes NO	Gender M F
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Dependent's Last Name	First	MI	Social Security #	Date of Birth	Relationship to Employee: Natural child, step child, etc.	Over the age of 18? Yes NO	Gender M F

If ANY person listed above has a different last name than the employee, please specify the relationship:

_____

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☐ **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**_____