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

☐ New Employee Form ☐ Enrollment Change Form

Employee Information

Name (Last, First, MI)________________ Gender ☐M ☐F Date of Birth________

Social Security Number____________ Phone#____________ Alternate #____________

Address________________ Unit/Apt #______ City__________ State______ Zip______

Email Address________________________

Medicare Eligible ☐Yes ☐No Medicare ID #________________

Marital Status ☐ Single ☐ Married-Date of Marriage ________ ☐ Divorced-Date of Divorce ________

If divorced and enrolling dependent children you will need to provide a copy of decree before claims will be processed

Spouse Information (See Definition on back side of this paper)

☐ Spouse Name (Last, First, MI)________________________ Disabled ☐ Yes ☐ No

Gender ☐M ☐ F Date of Birth__________ Social Security Number______________

Other Health Insurance ☐ Yes ☐ No Insurance Company______________________

Policy # ____________________Health record #____________________

Medicare Eligible ☐Yes ☐No Medicare ID #________________

Dependent Information (Please see reverse for definition of dependent.)

Child Name (Last, First, MI)________________________ Disabled ☐ Yes ☐ No

☐ Biological Child ☐ Step Child ☐ Adopted Gender ☐M ☐ F Date of Birth____________

Social Security Number________________ Other health Insurance ☐ Yes ☐ No

Insurance Company________________________ Policy # ______________

Health Record #____________________

Medicare Eligible ☐Yes ☐No Medicare ID #________________

Child Name (Last, First, MI)________________________ Disabled ☐ Yes ☐ No

☐ Biological Child ☐ Step Child ☐ Adopted Gender ☐M ☐ F Date of Birth____________

Social Security Number________________ Other health Insurance ☐ Yes ☐ No

Insurance Company________________________ Policy # ______________

Health Record #____________________

Medicare Eligible ☐Yes ☐No Medicare ID #________________

Child Name (Last, First, MI)________________________ Disabled ☐ Yes ☐ No

☐ Biological Child ☐ Step Child ☐ Adopted Gender ☐M ☐ F Date of Birth____________

Social Security Number________________ Other health Insurance ☐ Yes ☐ No

Insurance Company________________________ Policy # ______________

Health Record #____________________

Medicare Eligible ☐Yes ☐No Medicare ID #________________

List additional dependents on reverse.

Important-Your application cannot be processed without your signature. Please read the back of this form before signing

I acknowledge by my signature that the information I have supplied on this form is true and correct and that I have read and agree to the requirements, terms, conditions, limitations, and provisions described on the back of this form

Employee Signature________________________________ Date___/____/_____

List additional dependents on reverse side

List additional dependents here:

Child Name (Last, First, MI)______________________________ Disabled ☐ Yes ☐ No
☐ Biological Child ☐ Step Child ☐ Adopted Gender ☐M ☐ F Date of Birth______________
Social Security Number______________________ Other Health Insurance ☐ Yes ☐ No
Insurance Company______________________________ Policy # ______________
Health Record #______________________
Medicare Eligible ☐Yes ☐No Medicare ID #______________________

Child Name (Last, First, MI)______________________________ Disabled ☐ Yes ☐ No
☐ Biological Child ☐ Step Child ☐ Adopted Gender ☐M ☐ F Date of Birth______________
Social Security Number______________________ Other Health Insurance ☐ Yes ☐ No
Insurance Company______________________________ Policy # ______________
Health Record #______________________
Medicare Eligible ☐Yes ☐No Medicare ID #______________________

Child Name (Last, First, MI)______________________________ Disabled ☐ Yes ☐ No
☐ Biological Child ☐ Step Child ☐ Adopted Gender ☐M ☐ F Date of Birth______________
Social Security Number______________________ Other Health Insurance ☐ Yes ☐ No
Insurance Company______________________________ Policy # ______________
Health Record #______________________
Medicare Eligible ☐Yes ☐No Medicare ID #______________________

Definition of Spouse

A subscriber's lawful spouse is eligible for coverage (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".

Definition of Dependent Children

For purposes of determining eligibility, the following are considered children:

a. The natural or adopted child of a subscriber or a subscriber's spouse
b. Children placed for adoption with a subscriber. Adoption paperwork must be provided
c. Children related to a subscriber by blood or marriage for whom the subscriber is the legal guardian. A court order showing legal guardianship must be provided.

The following information is required prior to the processing of claims:

- Copies of Social Security Cards for all Dependants.
- Copy of State provided Marriage Certificate.
- Copies of Birth Certificates for dependent children.
- Copies of medical support or divorce decrees for step-children to determine coordination of benefits.

A subscriber's children are eligible until their 26th birthday. Children eligible due to a court or administrative order are subject to the Plan's child age limit.