

TEAMSTERS 206 EMPLOYERS TRUST
700 NE Multnomah Suite 350
Portland, Oregon 97232-4197
Phone (503) 238-6961 Toll Free (866) 230-6313

PLEASE PRINT

EMPLOYEE INFORMATION

EMPLOYEE

LAST NAME

FIRST NAME

MIDDLE INITIAL

SOCIAL SECURITY NUMBER: _____

BIRTHDATE: _____

GENDER: M ☐ F ☐

MAILING ADDRESS: _____

CITY: _____

STATE: _____

ZIP CODE: _____

PHONE NUMBER: _____

LOCAL NO: _____

EMPLOYER: _____

I AM SUBMITTING

☐

AS A NEW PARTICIPANT

☐

TO UPDATE INFORMATION

☐

TO ADD OR DELETE FAMILY MEMBERS

MARITAL STATUS:

☐

MARRIED

DATE OF MARRIAGE _____

☐

DIVORCE

DATE OF DIVORCE _____

☐

SINGLE

☐

WIDOWED

☐

LEGALLY SEPARATED

CHOOSE ONE MEDICAL PLAN:

☐

TRUST PLAN

☐

KAISER

CHOOSE ONE DENTAL PLAN:

☐

MODA

☐

KAISER

IF YOU CHOSE KAISER, PLEASE COMPLETE THE KAISER ENROLLMENT FORM AND RETURN WITH THIS COMPLETED FORM.

DO YOU OR YOUR DEPENDENTS HAVE OTHER MEDICAL AND/OR DENTAL COVERAGE?

☐

YES

☐

SELF

TYPE OF COVERAGE:

☐

MEDICAL

☐

DENTAL

☐

BOTH

☐

NO

☐

DEPENDENTS

NAME/ADDRESS OF

CARRIER: _____

DEPENDENT INFORMATION

SPOUSE NAME: _____

LAST NAME

FIRST NAME

MIDDLE INITIAL

GENDER: M ☐ F ☐

SOCIAL SECURITY NUMBER: _____

BIRTHDATE: _____

EMPLOYER: _____

ALL ELIGIBLE DEPENDENTS MUST BE LISTED

1. NAME: _____

LAST NAME

FIRST NAME

MIDDLE INITIAL

CHECK IF STEPCHILD

☐

SOCIAL SECURITY NUMBER: _____

BIRTHDATE: _____

SEX: M ☐

F ☐

2. NAME: _____

LAST NAME

FIRST NAME

MIDDLE INITIAL

CHECK IF STEPCHILD

☐

SOCIAL SECURITY NUMBER: _____

BIRTHDATE: _____

SEX: M ☐

F ☐

3. NAME: _____

LAST NAME

FIRST NAME

MIDDLE INITIAL

CHECK IF STEPCHILD

☐

SOCIAL SECURITY NUMBER: _____

BIRTHDATE: _____

SEX: M ☐

F ☐

4. NAME: _____

CHECK IF STEPCHILD

☐

SOCIAL SECURITY NUMBER: _____

BIRTHDATE: _____

SEX: M ☐

F ☐

PLEASE LIST ADDRESSES OF DEPENDENTS IF DIFFERENT FROM EMPLOYEE'S

1. _____

2. _____

LIFE INSURANCE BENEFICIARY INFORMATION

1. PRIMARY BENEFICIARY _____

RELATIONSHIP TO _____

2. CONTINGENT BENEFICIARY _____

SIGNATURE: _____

DATE: _____