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:** _____ **SEX:** **M** ☐ **F** ☐

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

DATE OF HIRE: _____ **PHONE NUMBER:** _____ **LOCAL NO:** _____

EMPLOYER: _____ **EMAIL:** _____

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 ☐ PROVIDENCE HEALTH PLAN

CHOOSE ONE DENTAL PLAN: ☐ MODA ☐ KAISER

IF YOU CHOSE PROVIDENCE HEALTH PLAN, PLEASE COMPLETE THE PROVIDENCE HEALTH PLAN ENROLLMENT FORM AND RETURN WITH THIS COMPLETED FORM.

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 ☐ YES ☐ SELF

TYPE OF COVERAGE: ☐ MEDICAL ☐ DENTAL ☐ BOTH ☐ NO ☐ DEPENDENTS

NAME/ADDRESS OF CARRIER: _____

DEPENDENT INFORMATION

SPOUSE: _____
LAST NAME **FIRST NAME** **MIDDLE INITIAL**

SOCIAL SECURITY NUMBER: _____ **BIRTHDATE:** _____ **SEX:** **M** ☐ **F** ☐

EMPLOYER: _____

ALL ELIGIBLE DEPENDENTS MUST BE LISTED

1. **NAME:** _____ **CHECK IF STEPCHILD** ☐
LAST NAME **FIRST NAME** **MIDDLE INTIAL**
SOCIAL SECURITY NUMBER: _____ **BIRTHDATE:** _____ **SEX:** **M** ☐ **F** ☐
2. **NAME:** _____ **CHECK IF STEPCHILD** ☐
LAST NAME **FIRST NAME** **MIDDLE INTIAL**
SOCIAL SECURITY NUMBER: _____ **BIRTHDATE:** _____ **SEX:** **M** ☐ **F** ☐
3. **NAME:** _____ **CHECK IF STEPCHILD** ☐
LAST NAME **FIRST NAME** **MIDDLE INTIAL**
SOCIAL SECURITY NUMBER: _____ **BIRTHDATE:** _____ **SEX:** **M** ☐ **F** ☐
4. **NAME:** _____ **CHECK IF STEPCHILD** ☐
LAST NAME **FIRST NAME** **MIDDLE INITIAL**
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 MEMBER:** _____
2. **CONTINGENT BENEFICIARY** _____ **RELATIONSHIP TO MEMBER:** _____

SIGNATURE: _____ **DATE:** _____