Local No.: _____

ALASKA CARPENTERS TRUST FUNDS

PLEASE PRINT ENROLLMENT / BENEFICIARY DESIGNATION FORM F40

Indicate reason for completing this form:
☐ New Participant ☐ Address Change ☐ Add/Term Dependent(s) ☐ Change Name ☐ Change Beneficiary

MEMBER/EMPLOYEE INFORMATION - PLEASE PRINT

Name (last, first, middle initial)		Social Security Number
Mailing Address		Birth Date
City State Zip		Phone No. ( )
Sex: ☐M ☐F	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	If married, date of marriage:

OTHER INSURANCE INFORMATION

Are you, your spouse, or other dependents covered by any other group medical insurance plan including Medicare? ☐Yes ☐No If Medicare, copy of Medicare ID card must be on file with the Administration Office.	
If "yes", please provide other insurance information: Name of Subscriber with Other Coverage:	Subscriber Soc. Sec. No.
Name and Address of Other Insurance Company:	Policy or ID Number:
Other insurance covers: □ Employee □ Spouse □ Children Other insurance includes: □ Medical □ Dental □ Vision	Date other coverage began:

MEMBERS OF MY FAMILY TO BE COVERED BY HEALTH & WELFARE

FULL NAME OF DEPENDENT	DATE OF BIRTH	SEX M / F	SOCIAL SECURITY NUMBER	RELATIONSHIP	Check if step, foster or adopted child

***Important Note:** Adult children, ages 19 to 26, which have their own employer-based coverage available to them, are not eligible to participate. The Trust Fund may require documentation such as a birth certificate, legal guardianship order and marriage certificate if the adult child is married.

BENEFICIARY DESIGNATION – It is important for you to name beneficiaries in case of your death. If you select an ineligible beneficiary or do not designate a beneficiary, your death benefit(s) will be paid in the order of preference (if any) outlined in the Plan Documents. *IMPORTANT NOTE*: Not every participant receives benefits under all of these plans, the type of benefits available to you are determined by your collective bargaining agreement. **List primary beneficiary in #1 of each benefit listed below and secondary beneficiary in #2.**

BENEFIT TYPE	**NAME OF BENEFICIARY** (Last, First, MI)	**RELATIONSHIP**	**BIRTHDATE** Month/day/year
Health and Welfare	1.		
	2.		
Defined Benefit - Only For Locals 1281 & 2247	1.		
	2.		
Defined Contribution	1.		
	2.		

I hereby certify that the above information is true, correct and complete to the best of my knowledge and supersedes any beneficiary designation signed prior to the date shown below. I am an eligible participant as a member of a bargaining unit, retiree, or covered by special agreement.

Date _____ Signature *(must be signed by participating employee)* _____

RETURN WHITE COPY TO: ADMINISTRATION OFFICE, PO BOX 34203, SEATTLE, WA 98124-1203