

Open Enrollment 2026



Address: 220 S 27th St, #B, Tacoma WA 98402

Phone: (253) 474-1214 or (800) 223-2449

Fax: (253) 474-7180

E-mail: elig@unitedemployees.org

Website: www.unitedemployees.org

Medical Dental Vision Time Loss

ENROLLMENT (Please print. Form must be completed in its entirety, signed and dated)

- Failure to return this completed enrollment form within 30 days could delay enrollment for your dependents.
- Benefits under the Trust cannot be provided until a completed enrollment form and required documents have been received. If the Enrollment Form or required documents are received 12-months after the effective date of coverage, eligibility will be updated for perspective benefits only.

ENROLLMENT Update (Please indicate reason for update)

- Enrolling Spouse (Notification of Marriage) Enrolling Child(ren) Change of Address, phone, email
- Deleting Spouse (Notification of Legal Separation or Divorce) Other: _____

Once enrolled you can register at www.unitedemployees.org to update enrollment and upload documents.

PARTICIPANT

Employer: _____ Date of Hire: _____ Union Local: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ Unit# _____ City, St, Zip: _____

Phone Number: _____ Email Address: _____

SSN or UEBT ID#: _____ Date of Birth: _____ Female Male

Marital Status: Single Married - Date _____ Widowed Divorced/Legally Separated - Date _____

Are you entitled to Medicare? Yes – Effective: _____ Part “A” Effective: _____ Part “B” Effective: _____

Are you covered under other health insurance Yes No *If yes, please provide this information in the Other Insurance section or include a photocopy of the front and back of your insurance identification card.*

Dependent Enrollment Yes, I have dependents to enroll – complete page 2. No, I do not have dependents to enroll.

LIFE INSURANCE - DESIGNATION OF BENEFICIARY (Medical Plan Benefit Only)

I, (employee name) _____, hereby designate as my beneficiary in the event of my death to receive the Employee Life Insurance and Accidental Means Death and Dismemberment Insurance benefits as set forth in the United Employees Benefit Trust Certificate to the individual listed below. If you want to have multiple beneficiaries, please attach an additional sheet identifying the beneficiaries and their percentage of your death benefit

_____	_____	_____
Primary Beneficiary	Relationship to Member	Phone Number

_____	_____	_____
Contingent Beneficiary	Relationship to Member	Phone Number

NOTE: This Designation of Beneficiary becomes effective upon receipt by the Trust when properly filled out and executed by the eligible employee and remains in effect until receipt by the Trust of a new Designation of Beneficiary or written notice absence of valid designation by the employee, the Trust Certificate will determine the beneficiary.

VERIFICATION

By my signature below, I am certifying that the information provided is true and correct to the best of my knowledge and belief. I further recognize that I have an obligation to inform the Trust and update the information provided if it changes in the future.

_____	_____
Member's Signature	Date Signed

DEPENDENTS (If you have more than 3 dependent children, please make a copy of this page or attach a separate piece of paper)

Social Security Number (SSN) is required for enrollment and Legal documents are required to verify dependency.

Spouse – Copy of Certified Marriage Certificate required (if county seal is on the back of the certificate, please include that page). If you divorce after beginning coverage in the Trust you are required to notify the Trust and provide a copy of the first and last page of the divorce decree confirming date of divorce. Domestic partners are not eligible.

Child – Copy of Certified Birth Certificate required Additional information may be required if natural parents are divorced or separated. If applicable, Proof of Adoption or Legal Guardianship required.

SPOUSE SSN: _____ Date of Birth: _____ Female Male

Last Name: _____ First Name: _____ Middle Initial: _____

Phone Number: _____ Email Address: _____

Is spouse entitled to Medicare? Yes – Effective: _____ Part “A” Effective: _____ Part “B” Effective: _____

Is spouse covered under other health insurance Yes No *If yes, please provide this information in the Other Insurance section*

DEPENDENT SSN: _____ Date of Birth: _____ Female Male

Last Name: _____ First Name: _____ Middle Initial: _____

Relation: _____ Email: _____ Phone: _____

Does this dependent live with you? Yes No *If no, please provide mailing address, email and phone number*

DEPENDENT SSN: _____ Date of Birth: _____ Female Male

Last Name: _____ First Name: _____ Middle Initial: _____

Relation: _____ Email: _____ Phone: _____

Does this dependent live with you? Yes No *If no, please provide mailing address, email and phone number*

DEPENDENT SSN: _____ Date of Birth: _____ Female Male

Last Name: _____ First Name: _____ Middle Initial: _____

Relation: _____ Email: _____ Phone: _____

Does this dependent live with you? Yes No *If no, please provide mailing address, email and phone number*

OTHER INSURANCE

Are any dependents covered under other insurance or Medicare while covered on this plan? Yes No

If yes, please provide this information or include a photocopy of the front and back of the insurance identification card.

Name of individual(s) covered under this insurance: _____

Name of Insured: _____ Type of Coverage: Medical Rx Vision Dental

Name of Insurance Company: _____ Phone Number: _____

Group/Policy#: _____ Plan ID#: _____ Effective Date: _____

If the insured is not enrolled in UEBT; please provide dependents relationship to insured: _____

Name of individual(s) covered under this insurance: _____

Name of Insured: _____ Type of Coverage: Medical Rx Vision Dental

Name of Insurance Company: _____ Phone Number: _____

Group/Policy#: _____ Plan ID#: _____ Effective Date: _____

If the insured is not enrolled in UEBT; please provide dependents relationship to insured: _____