Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111

Enrollment Form – Surviving Spouse

Please complete this form in its entirety and return it to the Trust Office as soon as possible.

General Information

Carpenter's name: ____ SSN: ________________________

Your name: ____ SSN: ________________________

Street address: ____

City, state, zip: ____

Telephone number: (   ) __________________________________ Date of birth: _________________

Eligible dependents (list dependent's legal name)   Date of birth   Relationship

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Life Insurance Beneficiary

Please designate a life insurance beneficiary below. Your beneficiary can be anyone except an employer. It is important to update this enrollment form if your status changes. New enrollment forms are available from the Trust Office or at www.ctww.org.

Beneficiary's name: ____ SSN: ________________________

Street address: ____

City, state, zip: ____

Telephone number: (   ) __________________________________ Date of birth: _________________

Signature: ____ Date: ________________________