

**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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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](http://www.ctww.org).

Beneficiary's name: \_\_\_\_\_ SSN: \_\_\_\_\_

Street address: \_\_\_\_\_

City, state, zip: \_\_\_\_\_

Telephone number: (        ) \_\_\_\_\_ Date of birth: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_