

## FAMILY ENROLLMENT FORM Single Employer

**COMPLETE AND RETURN TO ADDRESS SHOWN ABOVE**

Name of Employee: \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
Must be same name as reflected on your social security card

Address \_\_\_\_\_  
(street number and street name)  
 \_\_\_\_\_ Telephone No.: (\_\_\_\_) \_\_\_\_\_  
(city, state, zip code)

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Local Union No.: \_\_\_\_\_ Current Employer \_\_\_\_\_  
(name, city, state, zip code)

Job Class: (circle one) Journeyman (or above) Apprentice Construction Elec. Construction Wireman Non-Bargained-for Other: \_\_\_\_\_

Coverage Election: (circle one) Employee Only Employee+ Spouse Employee + Children Family

Date of Birth \_\_\_\_\_ Sex: M F Marital Status: Single Married/Date \_\_\_\_\_ Div Sep Legally Sep. Widowed  
(circle one) (circle one)

**NEW EMPLOYEES OR NEW SPOUSES—ATTACH CERTIFIED COPY OF MARRIAGE CERTIFICATE.**

Name of Spouse \_\_\_\_\_ Sex: M F Date of Birth \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
(circle one)

Name of any family member through which other group coverage is provided \_\_\_\_\_

Name, address, telephone no., and group/member I.D.s for that health plan \_\_\_\_\_  
 \_\_\_\_\_

**List all dependent children under age 26**

Full Legal Name	Relationship to you (natural child, step-child, etc.)	Does child live with you?	Child's Social Security Number	Date of Birth	Sex
1.					
2.					
3.					
4.					
5.					
6.					

FOR ANY NEWLY ENROLLED CHILD LISTED ABOVE, PLEASE SUBMIT CERTIFIED BIRTH CERTIFICATE AND COPIES OF ALL PERTINENT COURT ORDERS (DIVORCE DECREES, CUSTODY AWARDS, PATERNITY ORDERS, ETC.).

**LIFE INSURANCE BENEFICIARY**

Designate one or more beneficiaries for your Life Insurance and AD&D Insurance benefits.

**Primary Beneficiary(ies):**

Full Legal Name	Relationship to You	Social Security Number	Date of Birth	% of total (must equal 100%)

**Contingent Beneficiary(ies)** - Insurance benefits will only be paid to a contingent beneficiary if there is no surviving primary beneficiary:

Full Legal Name	Relationship to You	Social Security Number	Date of Birth	% of total (must equal 100%)

The above-named beneficiary supersedes any and all beneficiaries previously designated. Designation of a beneficiary on this form will be valid only if the Fund Office receives this form while you (the employee) are still living.

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Employee Signature