

LOCAL 15

A, C, D WELFARE FUND

WELFARE FUND ENROLLMENT FORM



The information on this form is needed by the Fund Office in order to provide benefits to you and your family.



Make sure to fill out all the fields. Incomplete forms will not be processed.



Print Clearly.



Make sure you submit with this form the supporting documentation. Forms submitted without proper supporting documentation, will not be processed.

Not sure about what constitutes supporting documentation? Refer to the section of your Welfare Fund Summary Plan Description Book entitled "Enrollment" or the back of this form for the list.

Policy Holder Information

Social Security Number: _____

Name: _____
First Middle Last Suffix (Jr., II etc)

Date of Birth (Month/Day/Year) _____ Sex: Male _____ Female _____

Marital Status (Please Circle): Single Married Divorced Widowed Separated

Street Address Apt # City State Zip

Home Phone # _____ Cell # _____

E-Mail Address _____

I declare the information on this form is true and complete. I agree to provide additional documentation to confirm this information if requested by the Welfare Fund. I agree to immediately notify the Welfare Fund of any changes in this information and understand that if I fail to do so and receive or attempt to receive benefits, the Welfare Fund will consider that an act of fraud against the Plan. I fully understand that if this occurs the Welfare Fund may terminate my or my dependents benefits, withhold any other benefits that may be payable to me or my dependents, take legal action against me in order to recover administrative costs, legal fees, interest or any amounts paid, and notify the appropriate authorities about criminal proceeding's.

Signature: _____ Date: _____

Notice: Participants are reminded that:

1. Enrollment into the Plan does not guarantee that a participant is eligible to receive benefits.
2. All participants will be enrolled in the Plan on the first day of the following month from the date the Fund Office receives and deems complete all supporting documentation.
3. If any of the requested information or documentation is either missing, or incomplete, the Fund will not be able to provide medical benefits to you or your dependents.
4. Participants must notify the Fund Office about a divorce, legal separation, or other insurance coverage such as, a spouse's insurance coverage, a Social Security Award, Workers' Compensation Award, or a child losing dependent status under the Plan within 60 days from the occurrence of the event.
5. Participants are strongly encouraged to familiarize themselves with the Enrollment, Eligibility and Fraud provisions of this Plan.



Dependent Information

Spouse Information

SS# _____ Date of birth _____

Name: _____
First Middle Last Suffix (Jr., II etc)

Dependent Information

Dependent #1 SS# _____ Date of birth _____

Name: _____
First Middle Last Suffix (Jr., II etc)

Please circle one: Biological Step Child Adopted Other

Dependent #2 SS# _____ Date of birth _____

Name: _____
First Middle Last Suffix (Jr., II etc)

Please circle one: Biological Step Child Adopted Other

Dependent #3 SS# _____ Date of birth _____

Name: _____
First Middle Last Suffix (Jr., II etc)

Please circle one: Biological Step Child Adopted Other

Dependent #4 SS# _____ Date of birth _____

Name: _____
First Middle Last Suffix (Jr., II etc)

Please circle one: Biological Step Child Adopted Other



Supporting Documentation

Spouse Marriage Certificate
 Social Security Card
 Insurance information if applicable
 Divorce papers if applicable

Your Child < 26 Birth Certificate
 Social Security Card
 Insurance information of natural parent if applicable
 Proof of name and date of birth of natural parent if applicable

Step Child < 26 Birth Certificate
 Social Security Card
 Insurance information of natural parent
 Judgment of Divorce / Settlement Decree

Adopted Child < 26 Adoption papers
 Social Security Card

Your Mother and/or Father Birth Certificate(s)
 Social Security Card(s)
 Tax filing showing individual as dependent (Must be submitted annually —
 Fund may require IRS Form 8821 — Tax Information Authorization)

The Welfare Fund reserves the right to request additional information in order to prove dependent status for eligibility purposes.



For Office Use Only

Date Received: _____ Date Entered: _____

Name of Individual Entering Information: _____

Date Mailed Back to Participant: _____

Form Was Deemed: Complete Incomplete

Member: Requested information missing Supporting documentation missing
 Form not signed

Spouse: Requested information missing Supporting documentation missing

Child: Requested information missing Supporting documentation missing

Child: Requested information missing Supporting documentation missing

Child: Requested information missing Supporting documentation missing

Child: Requested information missing Supporting documentation missing

Comments: _____

Signed: _____ Date: _____





The Welfare Fund will provide you with signed confirmation attesting to the receipt of this document. If you do not receive this verification, it means the Welfare Fund never received your Welfare Fund Enrollment Form.