

**BENEFIT ENROLLMENT FORM**  
**ASBESTOS WORKERS UNION LOCAL 42 WELFARE FUND**  
 7130 Columbia Gateway Drive, Suite A, Columbia, Maryland 21046  
 (410) 872-9500

**Member Information**

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Last First Init

Address \_\_\_\_\_  
 \_\_\_\_\_  
 Street City State Zip  
 Sex Date of Birth ( )  
 Male  Female \_\_\_\_\_  
 Mo. Day Yr. Telephone  
 Local Union No. \_\_\_\_\_

**Dependent Information**

See Summary Plan Description for definition of ELIGIBLE DEPENDENT

	Date of Marriage	Social Security Number	Date of Birth	Sex		Relationship
				M	F	
Spouse: _____	—	—				spouse
Dependents: (1) _____	—	—				
(2) _____	—	—				
(3) _____	—	—				
(4) _____	—	—				
(5) _____	—	—				

NOTE: IF A DEPENDENT HAS A DIFFERENT ADDRESS CHECK HERE  NAME \_\_\_\_\_

**ADDING OR DELETING DEPENDENTS**

If Eligible Dependent information listed on this Enrollment Form amends dependent information already on file with the Fund Office, please place a check here  and enclose supporting documentation (birth certificate, adoption order, marriage license, divorce decree, legal separation order, etc.). The change will not be recorded until the supporting document is received. The Fund will not pay claims on a Dependent until that Dependent is added to your coverage and filed with the Fund Office. An employee may not remove a Dependent who continues to qualify as a Dependent under the Plan.

**Designation of Beneficiary for Death Benefits**

I acknowledge that the Fund will pay death benefits according to the most recent beneficiary designation received in the Fund Office prior to my death.

Name of Primary Beneficiary \_\_\_\_\_ SSN: \_\_\_\_\_  
 Last First Init Relationship  
 Address (Complete if Beneficiary's address is not the same as Member's)  
 \_\_\_\_\_  
 Street City State Zip  
 Name of Secondary Beneficiary \_\_\_\_\_ SSN: \_\_\_\_\_  
 Last First Init Relationship  
 Address (Complete if Beneficiary's address is not the same as Member's)  
 \_\_\_\_\_  
 Street City State Zip

I acknowledge that the Plan requires me to reimburse the Plan if I or my dependent recover any amounts from a third party for an illness or injury for which the Plan has paid benefits, or if benefits are paid to me in error.

Date \_\_\_\_\_ Signature of Member \_\_\_\_\_

**Fund Office Use Only**

Date Received	Date Entered
Init _____	

