

BENEFIT ENROLLMENT FORM
FOOD & BEVERAGE WORKERS UNION LOCAL 23 & EMPLOYERS PENSION FUND
SERVICE WORKERS TRAINING AND EDUCATION PARTNERSHIP

7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046
Telephone: (410) 872-9500

Member Information

<u>Name</u>			Social Security Number	
_____	_____	_____	_____	_____
Last	First	Init		
<u>Address</u>				
_____	_____	_____	_____	_____
Street	City	State	Zip	
<u>Date of Birth</u>			<u>Sex</u>	
____/____/____			Male <input type="checkbox"/> Female <input type="checkbox"/>	
Home Telephone No. (____) _____				
Mo. Day Yr.				
Cell Phone No. (____) _____			E-mail address: _____	

Designation of Beneficiary for Death Benefits

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

Name of Primary Beneficiary SSN: _____

Last	First	Init	Relationship
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Address (Complete if Beneficiary's address is not the same as the Member's)

Street	City	State	Zip
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Name of Secondary Beneficiary SSN: _____

Last	First	Init	Relationship
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Address (Complete if Beneficiary's address is not the same as the Member's)

Street	City	State	Zip
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Date _____ Signature of Member _____