

BENEFIT ENROLLMENT FORM
WASHINGTON WHOLESALEERS HEALTH AND 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 _____
 Telephone _____
 Mo. Day Yr. 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	