BENEFIT ENROLLMENT FORM
ASBESTOS WORKERS LOCAL UNION NO. 24 MEDICAL FUND
7130 Columbia Gateway Drive, Suite A, Columbia, Maryland 21046
(410) 872-9500

Member Information

Name

_____ Last _____ First _____ Init

Social Security Number

_____ - _____ - _____

Address

_____ Street _____ City _____ State _____ Zip

Sex

❑ Male ❑ Female

Date of Birth

_____
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 M	Sex F	Relationship
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	

Return original to the Fund Office. Retain last copy for your records.
This is not an application for insurance