FRINGE BENEFIT ENROLLMENT FORM
TEAMSTERS LOCAL UNION 966
7130 COLUMBIA GATEWAY DRIVE, SUITE A; COLUMBIA, MD 21046
410-872-9500 PHONE *PRINT ALL INFORMATION* *410-872-1276 FAX*

Last Name *First Name* *M.I.* *Social Security Number*

Home Address *City* *State* *Zip*

Date of Birth *Marital Status (Circle One)* *Single Married Divorced Widowed* *Date of Marriage*

List Below Names of Your Spouse and Children under age 26. For Your Spouse and Child, you must provide proof of the relationship. Attach additional page, if needed.

List Names in Order of Age – Oldest First	*Social Security No.*	*Check Relationship* *Spouse*	*Son*	*Daughter*	*Date of Birth* *Month*	*Day*	*Year*

Date of Employment **Name of Shop/Co. where you work** **Position/Job**

CERTIFICATION REGARDING SECONDARY INSURANCE COVERAGE

In addition to your coverage under the Plan, are you, your spouse or dependent children covered by another health plan (including Medicare Parts A, B and/or D)? _____ yes _____ no

IF YES, YOU MUST PROVIDE ALL OF THE FOLLOWING INFORMATION REGARDING THE OTHER HEALTH INSURANCE (If multiple coverage exists, please list same information for other coverage on the reverse of this form):

Covered Person's Name: _____ ***Policy No.:*** _____

Covered Person's Relationship to You: _____

Name of Other Health Plan: _____

Address of Other Health Plan: _____

Effective Date of Coverage: _____ Is coverage through an Employer or Other Group? ___ yes ___ no

If yes, Name of Employer or Other Group:_____

I hereby state that the information I have provided is true and accurate. I understand and acknowledge that the Plan may deny coverage for benefits if I or anyone acting on my behalf makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from me, or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided. Any material misrepresentation on the part of the covered person in making application for coverage, or any application for reclassification thereof, or for service there under shall render the coverage under this Plan null and void.

_____
Employee Signature

NOTARY

State of _____)
)SS:
County of _____)

Subscribed and Sworn to before me, this _____ day of _____, 20____. _____
Notary Public

(Continued on back!)

Beneficiary Designations

I hereby authorize the payment of any death benefit as follows:

	Primary		***Contingent***	
Health Fund	*Name (Last, First, MI)*		*Name (Last, First, MI)*	
	Address		*Address*	
	SSN	*Relationship*	*SSN*	*Relationship*
Pension Fund	*Name (Last, First, MI)*		*Name (Last, First, MI)*	
	Address		*Address*	
	SSN	*Relationship*	*SSN*	*Relationship*

_____ _____

Signature of Employee *Date*

Spousal Consent

If you are married and you wish to name someone other than your spouse as the beneficiary to your pension benefits, your spouse must consent to your designation by signing below in the presence of a Notary Public. YOUR BENEFICIARY DESIGNATION WILL NOT BE VALID UNLESS YOUR SPOUSE'S SIGNATURE IS NOTARIZED.

As the lawful spouse of the herein-named participant, I hereby certify that I agree with the pension beneficiary designation(s) made above. I understand that by doing so, I waive any and all rights to my spouse's death benefits and authorize the Administrator of the Teamsters Local Union 966 Pension Fund to pay all death benefits to the above named beneficiary(ies).

NOTARY

_____
Signature of Participant's Spouse

State of _____)
)SS:
County of _____)

Subscribed and Sworn to before me, this _____ day of _____, 20____. _____

Notary Public