BENEFIT ENROLLMENT FORM
THE NATIONAL ASBESTOS WORKERS MEDICAL FUND
THE NATIONAL ASBESTOS WORKERS PENSION 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 M	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 _____

Return top two (2) copies to the Fund Office. Retain last copy for your records.
This is not an application for insurance