PLEASE SUBMIT A COPY OF YOUR MARRIAGE CERTIFICATE AND/OR BIRTH CERTIFICATES FOR YOUR CHILDREN WITH THIS CARD.

RETURN TO: IAM DISTRICT NO. 15 HEALTH FUND
140 Sylvan Avenue – Suite 303
Englewood Cliffs, NJ 07632
201-947-8000 FAX 201-947-9192

ENROLLMENT CARD

NAME			SEX		SOCIAL SECURITY NO.
Last	First	Middle Init.	M	F	

ADDRESS			
Number and Street	City	State	ZIP

BIRTH DATE			HOME & CELL PHONE	EMAIL ADDRESS	UNION	
MONTH	DAY	YEAR	HOME NUMBER		LOCAL NO.	INITIATION DATE
			CELL NUMBER			

MARITAL STATUS (Check One)	DATE OF MARRIAGE	Beneficiary Name
☐ Married ☐ Single ☐ Divorced		Relationship to Employee / Birthdate of Beneficiary
☐ Separated Widow(er)		
CURRENT EMPLOYER	**HIRE DATE**	Address of Beneficiary

- LIST YOUR SPOUSE AND ELIGIBLE DEPENDENTS BELOW (refer to the Summary Plan Description for definitions of Spouse and Eligible Dependents).
- DO YOU OR ANY OF YOUR DEPENDENTS HAVE ADDITIONAL HEALTH COVERAGE? Yes ☐ No ☐ If Yes, Give Details Below.*

FIRST NAME INIT. LAST NAME (if different)	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER	DISABLED
	SPOUSE			
OTHER DEPENDENTS				
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO
				☐ YES ☐ NO

I certify that all information on this form is true and correct. I understand that my beneficiary designation will apply to any and all Funds for which I have not specifically requested, completed and filed a separate beneficiary designation form. The information on this card supersedes all previous information cards.

Signature of Employee **Date**

List Name and Address of Spouse's Employer

Name

Address

If you are not married but are claiming dependent children you must supply us with the following information.

Natural Parent Name

Address

Employer Name

Address

If any of your natural children do not live with you, please provide the name and address of the person with custody.

Name

Address

If natural parent is married you must supply the following information.

Name of Spouse

Employer Name

Address

Insurance

***COMPLETE SECTION BELOW IF YOU OR ANY OF YOUR DEPENDENTS HAVE ADDITIONAL HEALTH COVERAGE**

Provide a copy of the Medical ID Card(s) / Supply Information as It Appears on Your Policy.

		GROUP OR POLICY NO.	TYPE OF COVERAGE	IF GROUP-NAME OF CONTRACT HOLDER (Employer, Fund, Association, etc.)
Insured Name >			☐ Individual	
Group >			☐ Group	
Insured Name >			☐ Individual	
Group >			☐ Group	
Insured Name >			☐ Individual	
Group >			☐ Group	
Insured Name >			☐ Individual	
Group >			☐ Group	

IMPORTANT: MAKE SURE YOU HAVE SIGNED AND DATED ABOVE AND COMPLETED THE BENEFICIARY SECTION, WHICH WILL APPLY TO THE LODGE 447 FRINGE BENEFIT TRUST FUND UNLESS YOU HAVE FILED A SEPARATE BENEFICIARY DESIGNATION. A SEPARATE BENEFICIARY DESIGNATION FORM MUST BE FILED WITH THE MMPPP. (CALL OR WRITE THE FUND OFFICE FOR APPROPRIATE FORMS TO FILE SEPARATE BENEFICIARY DESIGNATIONS FOR OTHER FUNDS OR IF YOU WANT TO DESIGNATE MORE THAN ONE BENEFICIARY FOR THIS FUND.)

FOR FUND USE