LABORERS'

MEMBER ENROLLMENT FORM

2357 59th Street • St. Louis, MO 63110 • 314-644-2777 • www.stllaborers.com

Member Information:

SSN#: _____ _____ _____ Local #: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of Birth: _____

Marital Status: O Single O Married O Separated O Divorced

Date of Divorce: _____ Sex: O F O M

Beneficiary:

Name: _____

Relationship: _____ % of Assigned Benefit: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ SS#: _____

Spouse Information:

Name: _____

Date of Marriage: _____ Date of Birth: _____

SSN#: _____ _____ _____ Sex: O F O M

Do you live with the member? O Yes O No

Spouse's Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Do you work? O Yes O No

Spouse's Employer: _____

Do you have other insurance coverage? O Yes O No

If so, please complete the following:

Name of Insured: _____

Coverage Type: O Single O Family Effective: _____

O Medical O Dental O Vision O Rx

Name of Plan: _____ Phone: _____

This beneficiary designation applies to welfare (death), pension and vacation benefits, along with any Local Union death benefit unless you designate otherwise.

Dependent Information: Complete the following information on all children less than 26 years of age.

Name	Relationship	Date of Birth	SSN#

In order to activate coverage for any new eligible dependent you acquire, it is strongly recommended that you complete an enrollment form with respect to that new dependent and return it to the Benefit Office within 31 days after you acquire that dependent along with any required documentation. Coverage will be effective for that dependent retroactive to the date you acquired the new eligible dependent. You have 90 days after the birth of a child to provide a copy of the child's birth certificate. If you fail to submit a completed enrollment form or any required documentation other than a birth certificate within 31 days after you acquire a dependent or a birth certificate within 90 days after the birth of a child, coverage for that dependent will be effective the first of the month following receipt of the completed enrollment form, birth certificate or other required documentation, as applicable.

I/We certify the above information is true, complete and accurate to be best of my/our knowledge. I/We hereby authorize any physician, hospital, employer, insurance company, or other institution rendering care to furnish the Laborers' Welfare Fund with information regarding benefits to which I/We may be entitled. A photo copy of this authorization shall be considered as effective and valid as the original.

Member Signature: _____ Spouse Signature: _____ Date: _____