IRON WORKERS LOCAL NO. 12

890 Third Street
Albany, New York 12206

Telephone 518/434-1206
Fax 518/434-3466

FRINGE BENEFIT FUND OFFICE

ENROLLMENT STATEMENT

NAME _____
Last First Middle

ADDRESS _____
Street City State Zip

COUNTY _____ TELEPHONE # _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____ BOOK # _____

Please circle one: SINGLE MARRIED DIVORCED WIDOWED

ELIGIBLE DEPENDENTS

List below Names of your Dependents to be covered under the Iron Workers Local #12 Health Fund

	NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY #
1.				
2.				
3.				
4.				
5.				
6.				
7.				

***A copy of the Birth Certificate and Social Security Card for each dependent listed must be submitted with this form. If you are married, a copy of your Marriage Certificate must also be submitted.

MEMBER SIGNATURE: _____

DATE: _____

IRON WORKERS LOCAL NO. 12 HEALTH INSURANCE FUND
OTHER INSURANCE QUESTIONNAIRE

Member's Name: _____ **Member ID Number:** _____

SECTION A
Please answer all questions

1. Do you or your family members have **Medicare** insurance?
   ☐ NO ☐ YES *(If YES, complete **Section B**)*

2. Do you or your family members have access to other medical insurance coverage (including any other Blue Cross and Blue Shield plan)?
   ☐ NO ☐ YES *(If YES, Complete **Section C**)*

3. Are any of your family members currently subject to a divorce decree or court order?
   ☐ NO ☐ YES *(If YES, complete **Section D**)*

SECTION B
Medicare Information

Policyholder's Name: _____ Date of Birth: ___/___/___ Medicare HIC #: _____

Effective Date: Part A: ____/____/_____ Part B: ____/____/_____ Part D: ____/____/_____

Spouse's Name: _____ Date of Birth: ___/___/___ Medicare HIC #: _____

Effective Date: Part A: ____/____/____ Part B: ____/____/____ Part D: ____/____/____

If the policyholder is retired, please indicate retirement date: ____/____/____

Does the policyholder have Medicare due to: ☐ End-Stage Renal Disease and/or ☐ Disability?

Does the policyholder's spouse have Medicare due to: ☐ End-Stage Renal Disease and/or ☐ Disability?

SECTION C
Other Medical Insurance Coverage Information

(This applies to Medical Coverage only. Do not provide us with information regarding your Dental Coverage)

)id you or your family members take the other coverage offered through an employer or other source?:

☐ NO ☐ YES Monthly cost of other medical insurance: $_____

'YES, Other Insurance Carrier Name: _____

ddress: _____ Phone Number: (____) _____-_____

olicy #: _____ Effective / Termination Date: ____/____/____ ____/____/____

olicyholder's Name:_____ DOB: ____/____/____ SSN: _____

lease circle all that apply. Coverage Type: **Medical / Drug** Policy Type: **Active / Retiree / COBRA**

~Over~

List other members covered by this policy:

Name: _____ SSN: _____ DOB: ___/___/___

Name: _____ SSN: _____ DOB: ___/___/___

Name: _____ SSN: _____ DOB: ___/___/___

Name: _____ SSN: _____ DOB: ___/___/___

If you need more space, please attach another sheet.

SECTION D
Divorce Decree or Court Order Information

If divorce decree states that a parent **must** provide medical insurance for the dependent, what is the name and date of birth of the parent responsible?

Name of Dependent	DOB	Responsible Parent	DOB
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___

Please send a copy of the divorce decree or court order indicating responsibility.

Certification and Signature

To ensure we have the correct number in the event we need to contact you, please provide a daytime phone number where you can be reached between 8:00 am and 5:00 pm, Monday through Friday.

I certify that the information given is complete and true.

Print Name: _____ Daytime phone: (____) ____-_____

Member Signature: _____ Date: _____

Please return this form and copies of all other insurance cards.
Claims will be denied until all information is completed and received by the Fund Office.

Return this completed form and requested information to the Fund Office:

IRON WORKERS LOCAL NO 12
HEALTH INSURANCE FUND
890 Third St. 1st Floor
Albany, NY 12206
Phone: (518) 434-1206
Fax: (518) 434-3466

IMPORTANT *** IMPORTANT *** IMPORTANT ***IMPORTANT ** IMPORTANT

It is of the utmost importance that Active Participants of the Iron Workers Local No. 12 Pension Fund and Iron Workers Local No. 12 Health Insurance Fund keep their designation of beneficiary information current. A Beneficiary Statement should be updated when any changes in Participant's personal status, such as marriage, divorce, separation, birth, adoption, death etc. occur.

Please complete this designation of beneficiary form for your Iron Workers Local No. 12 Pension Fund Pre-Retirement Death Benefits and your Iron Workers Local No. 12 Health Insurance Fund Life Insurance Benefits.

We have also enclosed a copy of the designation of beneficiary form for your Iron Workers District Council of Western NY Pension Fund Pre-Retirement Death Benefits and your Iron Workers Local No. 12 Annuity Account for your completion.

You must have your signature notarized for both forms to confirm that the designated beneficiary is of your choosing. There is a Notary at the Fringe Benefit Fund Office as well as at most Financial Institutions. If you have any questions concerning this request please contact the Fringe Benefit Fund Office at (518)434-1206.

PRE-RETIREMENT DEATH BENEFIT UNDER THE PENSION FUND

(Multiple or Contingent Beneficiary should be listed on the back of this form)

Beneficiary Name: _____ Beneficiary Social Security #: XXX-XX-_____

Beneficiary Address: _____ Beneficiary Date of Birth: _____

Beneficiary Relationship to Participant: _____ Percentage of Benefit to Beneficiary: _____

LIFE INSURANCE BENEFIT UNDER THE HEALTH INSURANCE FUND

(Multiple or Contingent Beneficiary should be listed on the back of this form)

Beneficiary Name: _____ Beneficiary Social Security #: XXX-XX-_____

Beneficiary Address: _____ Beneficiary Date of Birth: _____

Beneficiary Relationship to Participant: _____ Percentage of Benefit to Beneficiary: _____

MEMBER/PARTICIPANT INFORMATION

Member Name: _____ Member Social Security #: XXX-XX-_____

Member Address: _____ Member Date of Birth: _____

Member Telephone #: _____

Member Signature: _____ Signature Date: _____

NOTARY SECTION

On the _____ day of _____ before me came _____
To me known to be the person described in foregoing statement and acknowledged to me that he/she executed the same.

_____ (SEAL)
Notary Public

PRE-RETIREMENT DEATH BENEFIT UNDER THE PENSION FUND

Multiple Beneficiary _______ Contingent Beneficiary _______

Beneficiary Name: ________________________________ Beneficiary Social Security #: XXX-XX-__________

Beneficiary Address:______________________________________ Beneficiary Date of Birth: ____________

Beneficiary Relationship to Participant: ____________________ Percentage of Benefit to Beneficiary: ____________

Multiple Beneficiary _______ Contingent Beneficiary _______

Beneficiary Name: ________________________________ Beneficiary Social Security #: XXX-XX-__________

Beneficiary Address:______________________________________ Beneficiary Date of Birth: ____________

Beneficiary Relationship to Participant: ____________________ Percentage of Benefit to Beneficiary: ____________

Multiple Beneficiary _______ Contingent Beneficiary _______

Beneficiary Name: ________________________________ Beneficiary Social Security #: XXX-XX-__________

Beneficiary Address:______________________________________ Beneficiary Date of Birth: ____________

Beneficiary Relationship to Participant: ____________________ Percentage of Benefit to Beneficiary: ____________

LIFE INSURANCE BENEFIT UNDER THE HEALTH INSURANCE FUND

Multiple Beneficiary _______ Contingent Beneficiary _______

Beneficiary Name: ________________________________ Beneficiary Social Security #: XXX-XX-__________

Beneficiary Address:______________________________________ Beneficiary Date of Birth: ____________

Beneficiary Relationship to Participant: ____________________ Percentage of Benefit to Beneficiary: ____________

Multiple Beneficiary _______ Contingent Beneficiary _______

Beneficiary Name: ________________________________ Beneficiary Social Security #: XXX-XX-__________

Beneficiary Address:______________________________________ Beneficiary Date of Birth: ____________

Beneficiary Relationship to Participant: ____________________ Percentage of Benefit to Beneficiary: ____________

Multiple Beneficiary _______ Contingent Beneficiary _______

Beneficiary Name: ________________________________ Beneficiary Social Security #: XXX-XX-__________

Beneficiary Address:______________________________________ Beneficiary Date of Birth: ____________

Beneficiary Relationship to Participant: ____________________ Percentage of Benefit to Beneficiary: ____________

Dear Local 12 Participant:

While working in the jurisdiction of the Iron Workers District Council of Western New York and Vicinity Pension Fund, you may become eligible for a **Pre-Retirement Death Benefit** of $350.00 per pension credit which your beneficiary may be entitled to in the event of your death.

Please fill in the following information and return it to us in the enclosed self-addressed envelope. You must have your signature notarized to assure us that the beneficiary is **your** choice.

PRE-RETIREMENT DEATH BENEFIT UNDER THE PENSION FUND

Beneficiary Name_____SS#_____

Date of Birth_____Relationship_____Percentage_____

Contingent Beneficiary (in the event of death of beneficiary)

Name_____SS#_____

Date of Birth_____Relationship_____Percentage_____

ADDITIONAL BENEFICIARIES

For additional beneficiaries or contingent beneficiaries

Beneficiary Name_____SS#_____

Date of Birth_____Relationship_____Percentage_____

Contingent Beneficiary Name_____SS#_____

Date of Birth_____Relationship_____Percentage_____

Beneficiary Name_____SS#_____

Date of Birth_____Relationship_____Percentage_____

Contingent Beneficiary Name_____SS#_____

Date of Birth_____Relationship_____Percentage_____

PLEASE provide the following member information:

_____ _____ _____

MEMBER SIGNATURE | SOCIAL SECURITY # | DATE OF BIRTH

_____

ADDRESS

Subscribed and sworn to before me this_____day of_____ in the year_____

Signature _____

NOTARY

Revised 6/15

Iron Worker's Local Union No. 12
Death Benefit Beneficiary Form

(Please Print & Complete In Full)

Member Name: _____ Member No.: _____
(Book Number)

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: ____/____/_____ Social Security No.: _____

In accordance with the International Constitution the disbursement of your death benefit follows the guidelines in Article XVIII at all times. In circumstances where there is not a living spouse or children, you may designate a beneficiary. Please complete the information in full.

Legal Spouse Information

(Your death benefit will be sent to your legal spouse in the event of your death)

_____ _____ ____ (____)____-_____
(Last Name) (First Name) (MI) (Telephone No.)

_____
(Address including apartment number, if any)

_____ _____ _____
(City, State, Zip Code) (Date of Birth) (Social Security No.)

Surviving Child

(Your death benefit will be divided equally amongst <u>all</u> surviving children if there is not a surviving spouse.)

_____ _____ ____ (____)____-_____
(Last Name) (First Name) (MI) (Telephone No.)

_____
(Address including apartment number, if any)

_____ _____ _____
(City, State, Zip Code) (Date of Birth) (Social Security No.)

Surviving Child

(Your death benefit will be divided equally amongst <u>all</u> surviving children if there is not a surviving spouse.)

_____ _____ ____ (____)____-_____
(Last Name) (First Name) (MI) (Telephone No.)

_____
(Address including apartment number, if any)

_____ _____ _____
(City, State, Zip Code) (Date of Birth) (Social Security No.)

(Continued on Reverse Side)

Surviving Child

(Your death benefit will be divided equally amongst all surviving children if there is not a surviving spouse.)

_____ _____ ____ (____)_____-_____

(Last Name) (First Name) (MI) (Telephone No.)

_____

(Address including apartment number, if any)

_____ _____ _____

(City, State, Zip Code) (Date of Birth) (Social Security No.)

Surviving Child

(Your death benefit will be divided equally amongst all surviving children if there is not a surviving spouse.)

_____ _____ ____ (____)_____-_____

(Last Name) (First Name) (MI) (Telephone No.)

_____

(Address including apartment number, if any)

_____ _____ _____

(City, State, Zip Code) (Date of Birth) (Social Security No.)

Appointed Beneficiary – Percentage of Benefit Out of 100%_____

(In the event there is no surviving spouse or children, you can appoint a beneficiary to receive your death benefit.)

_____ _____ ____ (____)_____-_____

(Last Name) (First Name) (MI) (Telephone No.)

_____

(Address including apartment number, if any)

_____ _____ _____

(City, State, Zip Code) (Date of Birth) (Social Security No.)

Appointed Beneficiary – Percentage of Benefit Out of 100%_____

(In the event there is no surviving spouse or children, you can appoint a beneficiary to receive your death benefit.)

_____ _____ ____ (____)_____-_____

(Last Name) (First Name) (MI) (Telephone No.)

_____

(Address including apartment number, if any)

_____ _____ _____

(City, State, Zip Code) (Date of Birth) (Social Security No.)

ignated beneficiaries will receive all death benefits in accordance with the guidelines of the International stitution, Article XVIII (not including those issued by the Fringe Benefit office) unless otherwise specified. If yu ire further room for Surviving Children, Appointed Beneficiaries or you would like a copy of the above Article, se contact the Union Hall at (518) 435-0470. **All forms must be notarized for identification verification.**

aber Signature: _____

Signed: _____

e return this completed form to:
orkers Local Union No. 12, Attn: General Fund
hird Street, Albany, NY 12206