

ENROLLMENT FORM

(PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING THIS FORM)

(PRINT OR TYPE IN BLACK INK AND IN CAPITAL LETTERS)

SECTION A: MEMBER'S INFORMATION

SOCIAL SECURITY NUMBER				LAST NAME				FIRST NAME				MI
DATE OF BIRTH MONTH / DAY / YEAR				GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				DATE OF HIRE MONTH / DAY / YEAR				DEPT./AGENCY
HOME STREET ADDRESS								APT. NO.		HOME PHONE () -		
CITY				STATE				ZIP CODE		CELL PHONE () -		
CURRENT STATUS: Please check one box.	NOTE: A date is required if an option other than single is selected				EDUCATION LEVEL: (Circle One)				WORK PHONE () -			
	<input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED MONTH DAY YEAR MONTH DAY YEAR MONTH DAY YEAR ___/___/___ ___/___/___ ___/___/___ <input type="checkbox"/> WIDOWED <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> SINGLE MONTH DAY YEAR MONTH DAY YEAR ___/___/___ ___/___/___				College: 1yr 2yr 3yr BA BS Other _____ High School Diploma or Equiv: <input type="checkbox"/> Yes <input type="checkbox"/> No If no High School Diploma, (Circle One) Highest Year Completed: _____ 4 5 6 7 8 9 10 11				Home E-Mail Address (Optional) _____			
<p>If you enroll any dependents, spouse or domestic partner, it is mandatory that you attach all required documents (i.e. BIRTH CERTIFICATE, MARRIAGE CERTIFICATE, ADOPTION DOCUMENTS or REGISTRATION OF DOMESTIC PARTNERS) before any benefits will be provided to dependents, spouse or domestic partner.</p>												

SECTION B: SPOUSE OR DOMESTIC PARTNER INFORMATION

SS# OF SPOUSE/DOMESTIC PARTNER				LAST NAME (If Different)				FIRST NAME				MI
DATE OF BIRTH MONTH / DAY / YEAR				GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE				NAME OF EMPLOYER				DATE OF HIRE MONTH / DAY / YEAR
WORK ADDRESS								ZIP CODE		WORK PHONE () -		
NAME OF SPOUSE/DOMESTIC PARTNER'S UNION/LOCAL # IF APPLICABLE								PHONE No. of SPOUSE/DOMESTIC PARTNER'S UNION/LOCAL () -				
ADDRESS/ZIP CODE OF SPOUSE/DOMESTIC PARTNER'S UNION/LOCAL # IF APPLICABLE												
Benefit	Name of Insurer	Address/Zip Code of Insurer	Phone # of Insurer	Policy #	Coverage Individual or Family							
Drug												
Dental												
Health Insurance												

SECTION C: DEPENDENT INFORMATION (NOTE - If there are additional dependents, please list on a separate page.)

DEPENDENT SS#	FIRST NAME	LAST NAME (IF DIFFERENT)	DATE OF BIRTH MONTH DAY YEAR ___/___/___	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RELATIONSHIP <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEP-SON <input type="checkbox"/> STEP-DAUGHTER OTHER: _____				
DEPENDENT SS#	FIRST NAME	LAST NAME (IF DIFFERENT)	DATE OF BIRTH MONTH DAY YEAR ___/___/___	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RELATIONSHIP <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEP-SON <input type="checkbox"/> STEP-DAUGHTER OTHER: _____				
DEPENDENT SS#	FIRST NAME	LAST NAME (IF DIFFERENT)	DATE OF BIRTH MONTH DAY YEAR ___/___/___	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RELATIONSHIP <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEP-SON <input type="checkbox"/> STEP-DAUGHTER OTHER: _____				
DEPENDENT SS#	FIRST NAME	LAST NAME (IF DIFFERENT)	DATE OF BIRTH MONTH DAY YEAR ___/___/___	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
RELATIONSHIP <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> STEP-SON <input type="checkbox"/> STEP-DAUGHTER OTHER: _____				

SECTION D: DEATH BENEFITS TO BE PAID TO

1) BENEFICIARY(IES): If more than one primary beneficiary is named, the Death Benefit will be divided equally among them, unless otherwise indicated.

LAST NAME OF BENEFICIARY		FIRST NAME			MI
BENEFICIARY ADDRESS				APT. #	CITY
STATE	ZIP CODE	TELEPHONE NUMBER	RELATIONSHIP	DATE OF BIRTH (MONTH / DAY / YEAR)	
LAST NAME OF BENEFICIARY		FIRST NAME			MI
BENEFICIARY ADDRESS				APT. #	CITY
STATE	ZIP CODE	TELEPHONE NUMBER	RELATIONSHIP	DATE OF BIRTH (MONTH / DAY / YEAR)	

2) CONTINGENT BENEFICIARY(IES) In the event the primary beneficiary(ies) predecease(s) the insured, I designate as contingent beneficiary(ies).

LAST NAME OF BENEFICIARY		FIRST NAME			MI
BENEFICIARY ADDRESS				APT. #	CITY
STATE	ZIP CODE	TELEPHONE NUMBER	RELATIONSHIP	DATE OF BIRTH (MONTH / DAY / YEAR)	
LAST NAME OF BENEFICIARY		FIRST NAME			MI
BENEFICIARY ADDRESS				APT. #	CITY
STATE	ZIP CODE	TELEPHONE NUMBER	RELATIONSHIP	DATE OF BIRTH (MONTH / DAY / YEAR)	

NOTE: If there are additional beneficiaries, please list on a separate page.

ATTENTION: I attest that the information entered on this form is true and accurate and I understand that I and my family may lose benefit coverage if any of the information given on this form is false.

I AUTHORIZE ANY DOCTOR, DENTIST, OTHER PRACTITIONER(S), HOSPITAL OR OTHER INSTITUTION(S) TO GIVE THE DC37 HEALTH AND SECURITY PLAN ANY INFORMATION IF REQUESTED WITH REFERENCE TO TREATMENTS, EXAMINATIONS, ADVICE OR CONFINEMENT IN A HOSPITAL, OR ANY OTHER INSTITUTION OF MYSELF, SPOUSE, DOMESTIC PARTNER OR DEPENDENTS.

X _____
MEMBER/EMPLOYEE SIGNATURE

X _____
SPOUSE/DOMESTIC PARTNER SIGNATURE

DATE

Health & DC37 Security Plan

Instructions on How to Complete The Attached Enrollment Form

In order for the DC 37 Health and Security Plan to provide Welfare Fund Benefits to you and your dependents you must complete the attached Enrollment Form.

PLEASE NOTE THE FOLLOWING:

- As a new employee, enrolling a spouse, domestic partner or dependent child (ren) in the Plan for the first time, you must attach the appropriate documentations (your marriage certificate, domestic partnership papers and birth certificate(s) of your child (ren) to your Enrollment Form.
- If you were previously enrolled and want to add or change your spouse, domestic partner or dependent information, please submit a “Change of Status Form”.
- Sign and date the Enrollment Form.
- Please send the Enrollment Form to the following address:

DC 37 Health and Security Plan

55 Water Street
New York, NY 10041
Tel: (212) 815-1234
Fax: (212) 298-9880
Email: eeu@dc37.net

If you have any questions, feel free to contact our Plan office at 212-815-1234.