1199SEIU LICENSED PRACTICAL NURSES WELFARE FUND

ENROLLMENT FORM

TIMES SQUARE STATION, PO BOX 2426, NEW YORK, NY 10108-2426 • (646) 473-9200

THIS FORM IS STRICTLY CONFIDENTIAL. YOU MUST ANSWER ALL THE QUESTIONS, PRINT CLEARLY IN INK AND SIGN THE BACK.

SECTION ONE - MEMBER INFORMATION

1. MEMBER NAME (Last) (First) (M.I.)

2. SOCIAL SECURITY NUMBER

3. DATE OF BIRTH Mo Day Year

4. SEX M ❐ F ❐

5. ADDRESS APT.#

CITY STATE ZIP CODE

6. AREA CODE & HOME PHONE NUMBER

7. MARITAL STATUS

8. MARRIAGE DATE Mo Day Year

8A. For purposes of statistical/demographic information, we ask you to provide the following information.
PLEASE CHECK ONE: ❐ White ❐ Black ❐ Latino ❐ Asian ❐ Other

9. SPOUSE'S FULL NAME (Last, First, Middle Initial) **Attach Copy of Marriage Certificate**

10. SPOUSE'S BIRTH DATE Mo Day Year

11. SPOUSE'S SOCIAL SECURITY NUMBER

12. YOUR CHILDREN'S NAME(S) **Attach Copy of Birth Certificate for Each Dependent**	13. SEX	14. DATE OF BIRTH	15. RELATIONSHIP	16. SOCIAL SECURITY NUMBER
1	❐ M ❐ F	Mo Day Year		
2	❐ M ❐ F	Mo Day Year		
3	❐ M ❐ F	Mo Day Year		
4	❐ M ❐ F	Mo Day Year		
5	❐ M ❐ F	Mo Day Year		

SECTION TWO - HEALTH CORPORATION EMPLOYER

17. YOUR EMPLOYER ______ WORK PHONE ______

18. ADDRESS ______

CITY ______ STATE ______ ZIP ______

19. STARTING DATE ______ 20. ❐ FULL-TIME ❐ PART-TIME ❐ PER DIEM ❐ TEMP. 21. HOURS PER WEEK ______ PAY PER WEEK $ ______

22. JOB TITLE ______ 23. DEPT. ______ 24. CHECK BOX IF REGISTERED NURSE ❐

25. IF YOU WORK FOR ANOTHER 1199SEIU EMPLOYER, NAME OF OTHER EMPLOYER ______

26. ADDRESS ______

CITY ______ STATE ______ ZIP ______

27. STARTING DATE ______ 28. ❐ FULL-TIME ❐ PART-TIME ❐ PER DIEM ❐ TEMP. 29. HOURS PER WEEK ______ 30. PAY PER WEEK $ ______

31. PLEASE INDICATE PREVIOUS EMPLOYMENT

	EMPLOYER	CITY	STATE	DATE STARTED			DATE ENDED		
				MONTH	DAY	YEAR	MONTH	DAY	YEAR
1									
2									
3									

PLEASE CONTINUE COMPLETION OF THIS FORM ON REVERSE SIDE

SECTION THREE - COORDINATION OF BENEFITS - OTHER HEALTH INSURANCE

32. NAME OF SPOUSE'S EMPLOYER ______________________

33. EMPLOYER'S ADDRESS ______________________
CITY ____________ STATE: ________ ZIP ________

34. DOES YOUR SPOUSE HAVE OTHER HEALTH INSURANCE COVERAGE? ❐ YES ❐ NO

35. IF YES, NAME OF INSURANCE PLAN ______________________

36. POLICY/GROUP NUMBER ______________________

37. Please indicate the type of coverage: ❐ Hospital ❐ Surgical ❐ Major Medical ❐ Medical (Office Visits, Lab) ❐ Vision ❐ Dental

38. DOES THIS PLAN ALSO INCLUDE PRESCRIPTION COVERAGE? ❐ YES ❐ NO

39. EFFECTIVE DATE OF COVERAGE ______________________

40. IS THIS COVERAGE INDIVIDUAL OR FAMILY? ❐ IND ❐ FAMILY

41. DOES YOUR DEPENDENT CHILD(REN) HAVE OTHER HEALTH INSURANCE? ❐ YES ❐ NO

42. IS THIS INSURANCE THE SAME AS ABOVE? ❐ YES ❐ NO

43. NAME OF OTHER PARENT ______________________

44. NAME OF OTHER PARENT'S EMPLOYER ______________________

45. ADDRESS OF OTHER PARENT'S EMPLOYER ______________________
CITY ______________________ STATE ________ ZIP ________

46. SOCIAL SECURITY # ______________________

47. DATE OF BIRTH ______________________

SECTION FOUR - BENEFICIARY INFORMATION

BENEFICIARY INFORMATION - FOR YOUR LIFE INSURANCE. Insert name and address of person (s) to whom your Life Insurance is to be paid. State how the person(s) are related to you. If a minor (under age 18), state age, and indicate the name of the person who will act as the Guardian in the "Remarks" Section below until the minor attains age 18. Please check the **PRIMARY** box for the person to whom you want this benefit paid. If you want to list someone else in case your **PRIMARY** choice dies before you, mark this person or person(s) as **SECONDARY**. If you want more than one person to share equally in this benefit, those individuals must be marked as **PRIMARY**. If additional space is needed please use the "Remarks" Section below or attach a separate sheet. (If you authorize the Fund to assign up to one-third of your insurance benefit directly to the funeral home or cemetery, if the Fund is notified that your funeral expenses have not been otherwise paid or guaranteed to be paid, check here ❐.)

48. NAME OF BENEFICIARY (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	❐ Primary ❐ Secondary	RELATIONSHIP TO MEMBER	BIRTH DATE (if under 18) Mo / Day / Year
STREET ADDRESS OF BENEFICIARY	CITY	STATE	ZIP CODE	
49. NAME OF BENEFICIARY (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	❐ Primary ❐ Secondary	RELATIONSHIP TO MEMBER	BIRTH DATE (if under 18) Mo / Day / Year
STREET ADDRESS OF BENEFICIARY	CITY	STATE	ZIP CODE	
50. NAME OF BENEFICIARY (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	❐ Primary ❐ Secondary	RELATIONSHIP TO MEMBER	BIRTH DATE (if under 18) Mo / Day / Year
STREET ADDRESS OF BENEFICIARY	CITY	STATE	ZIP CODE	

"REMARKS":

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This Enrollment Form is for Fund use only and will not be released to any third party except where necessary for the administration and operation of the Fund, or where otherwise required by law. THE FOREGOING STATEMENTS ARE TO THE BEST OF MY KNOWLEDGE TRUE AND COMPLETE.

MEMBER SIGNATURE ______________________ **DATE** ____________

IF YOU DO NOT **SIGN AND DATE** THIS FORM IT WILL BE RETURNED TO YOU AND YOU WILL NOT BE ENROLLED.
The Fund will be unable to send your Prescription Card or provide benefits to you or your eligible dependents if you do not complete this Enrollment Form and provide the required documents.