1199SEIU LICENSED PRACTICAL NURSES WELFARE FUND

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

ENROLLMENT FORM

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 (Mo / Day / Year)	15. RELATIONSHIP	16. SOCIAL SECURITY NUMBER
1	❒ M ❒ F			
2	❒ M ❒ F			
3	❒ M ❒ F			
4	❒ M ❒ F			
5	❒ M ❒ F			

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 MONTH	DAY	YEAR	DATE ENDED 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":

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.