ENROLLMENT FORM

ROAD CARRIERS LOCAL 707 WELFARE FUND

14 FRONT STREET, HEMPSTEAD, NEW YORK 11550 • (516) 486-7100

COMPLETE AND RETURN THIS FORM TO THE FUND AT THE ABOVE ADDRESS **DATE:**

MEMBER'S NAME (LAST - FIRST - MIDDLE)			SOCIAL SECURITY NO.	DATE OF BIRTH MO DAY YR
ADDRESS (NO. & STREET)			SEX	MARITAL STATUS ( ) Single ( ) Married ( ) Divorced
CITY	STATE	ZIP	EMPLOYER	DATE OF HIRE
TELEPHONE NO. AREA CODE ( )			COVERAGE REQUESTED: ( ) MAJOR MEDICAL ( ) HIP ( ) WELLCARE	

LIST EACH DEPENDENT SEPARATELY (List the name of your spouse and each unmarried child under 19 years of age)

Name and Address	Relationship (Check One)				Soc. Sec. No.	Date of Birth	Employer	Insurance Co.	Coverage Type				Single	Family
	Spouse	Son	Daughter	Other		MO DAY YR	Name & Address	Policy #	H	M	D	Other		
1.														
2.														
3.														
4.														
5.														
6.														
7.														
8.														
9.														

NOTE: IT IS YOUR OBLIGATION TO REPORT ALL OTHER INSURANCE COVERAGE. THIS INFORMATION SHALL BE USED TO PROCESS YOUR CLAIMS UNDER THE COORDINATION OF BENEFITS AND SUBROGATION PROVISIONS OF THE WELFARE PLAN. THE FUND RESERVES IT'S SUBROGATION RIGHTS AGAINST ANY THIRD PARTY RECOVERY. IF YOUR CLAIM IS PROCESSED ON THE BASIS OF ANY WILLFULLY FALSE INFORMATION WHICH YOU HAVE SUPPLIED, YOU MAY BE HELD LIABLE FOR FRAUD. (* H-Hospital; M-Medical; D-Dental; Other - specify)

LIFE INSURANCE - BENEFICIARY DESIGNATION:

Insurance proceeds will be payable to your named primary beneficiary. Should you wish to name more than one individual as your primary beneficiary, please specify each name and indicate the amount to be paid to each designee. If you are not survived by the primary beneficiary designated below, payment shall be made to your secondary beneficiary, or as further provided for under the Welfare Plan.

PRIMARY BENEFICIARY:

NAME: RELATIONSHIP

BENEFICIARY'S ADDRESS:

STREET NO. CITY STATE ZIP CODE

SECONDARY BENEFICIARY:

NAME: RELATIONSHIP

BENEFICIARY'S ADDRESS:

STREET NO. CITY STATE ZIP CODE

IF ANY INFORMATION PROVIDED SHOULD CHANGE, YOU ARE REQUIRED TO REPORT THAT CHANGE TO THE FUND OFFICE IMMEDIATELY.

MEMBER'S SIGNATURE: _____ DATE _____

OFFICIAL USE ONLY

EFFECTIVE DATE ENROLLED	SOCIAL SECURITY NUMBER	DATE MAILED

DATE	CANCELLED	REINSTATED	DATE	CANCELLED	REINSTATED

REV 12/92