WASHINGTON, D.C. CEMENT MASONS' TRUST FUND
PO Box 907, Troy, MI 48099
(410) 872-9500

Member Information

Name _____ (Last) _____ (First) _____ (Middle Initial) Social Security Number _____ - _____ - _____

Address _____ (Street and Apt. #) _____ (City) _____ (State) _____ (Zip)

Sex ☐ Male ☐ Female

Date of Birth _____ (Mo. Day Yr.)

(_____)_____ Telephone

Local Union No._____

Dependent Information

See Summary Plan Description for definition of ELIGIBLE DEPENDENT

		Date of Marriage	Social Security Number	Date of Birth	Sex M	Sex F	Relationship
Spouse:	(1)		- -				
Dependents:	(2)		- -				
	(3)		- -				
	(4)		- -				
	(5)		- -				

Note: IF A DEPENDENT HAS A DIFFERENT ADDRESS CHECK HERE ☐ NAME _____

ADDING OR DELETING DPEENDENTS

If Eligible Dependent information listed on this Enrollment Form amends dependent information already on file with the Fund Office, please place a check here ☐ and enclose supporting documentation (birth certificate, adoption order, marriage license, divorce decree, legal separation order, etc.). The change will not be recorded until the supporting documentation is received. The Fund will not pay claims on a Dependent until that Dependent is added to your coverage and filed with the Fund Office. An employee may not remove a Dependent who continues to qualify as a Dependent under the Plan.

Designation of Beneficiary for Death Benefits

I acknowledge that the Fund will pay death benefits according to the most recent beneficiary designation received in the Fund Office prior to my death.

Name of Primary Beneficiary SSN:_____

_____ (Last) _____ (First) _____ (Middle Initial) _____ (Relationship)

Address (Complete if Beneficiary's address is not the same as Member's)

_____ (Street and Apt. #) _____ (City) _____ (State) _____ (Zip)

Name of Secondary Beneficiary SSN: _____

_____ (Last) _____ (First) _____ (Middle Initial) _____ (Relationship)

Address (Complete if Beneficiary's address is not the same as Member's)

_____ (Street and Apt. #) _____ (City) _____ (State) _____ (Zip)

I acknowledge that the Plan requires me to reimburse the plan if I or my dependent recover any amounts from a third party for an illness or injury for which the Plan has paid benefits, or if benefits are paid to me in error.

Date _____ Signature of Member _____

FUND OFFICE USE ONLY

Date Received	**Date Entered**
Init	

Return original to the Fund Office. Retain last copy for your records.
This is not an application for insurance.