LIFE INSURANCE ENROLLMENT FORM

Planholder Name (Company Name)			Group Plan No.: **GL-164736**
HEALTH & WELFARE TRUST FUND OF INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 877 & 70			
Planholder Street Address	City	State	Zip

EMPLOYEE	**Please provide this information about YOURSELF**		
First Name, Middle Initial, Last Name:	Sex: ◯ M ◯ F	Date of Birth (mm/dd/yyyy)	Social Security No.
Address	City	State	Zip
The best way to reach you: ◯ Day Phone ◯ Evening Phone ◯ Email	Day Phone #	Evening Phone #	
	Email Address		
Employer	Job Title		

NAME YOUR BENEFICIARIES - Must add up to 100%

Primary Beneficiary 1	**Primary Beneficiary 2**	**Contingent Beneficiary**
Name (Last, First, MI)	Name (Last, First, MI)	Name (Last, First, MI)
Relationship to you: _____%	Relationship to you: _____%	Relationship to you: _____%

SIGNATURE

. I hereby apply for the group benefit(s) above.
. I understand that I must meet eligibility requirements for all coverage's above.
. I understand that I must be actively at work or my life and/or disability coverage will not take effect until I have completed a waiting period (as defined in the Group Plan) of full time service. This requirement does not apply to eligible retirees.
. I agree that my employer may deduct premiums from my pay; if they are required for the above coverage.
. I attest that the information provided above is true and correct to the best of my knowledge.
. Any person who with intent to defraud or knowing that he/she is facilitating a fraud against and insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

SIGNATURE OF EMPLOYEE	**DATE**

FOR FUND USE ONLY	
Class	Benefit Effective