□ Union □ Non-Union | □ FT □ PT

Local Union No. _____

MAN-U SERVICE CONTRACT TRUST FUND
PO Box 99184, Troy, MI 48099
Phone: (410) 872-9500 or (800) 638-8824 Fax: (410) 872-1275

NEW ENROLLMENT OR CHANGE FORM
(PLEASE PRINT EXCEPT FOR SIGNATURE)

☐ New
☐ Change
(check one)

Employee Name:_____ **SSN**:_____-_____-_____ **Sex:** M / F
(Last) (First) (MI) (Circle)

Address:_____ **DOB:**_____
(Street/P.O. Box)

_____ **Phone:**_____
(City) (State) (Zip)

Marital Status: (Check One) ☐ Single ☐ Married: Date_____ ☐ Divorced: Date_____ ☐ Widow/Widower

Employer Name:_____ **Hire Date:** _____

Address_____

Coverage Election: ☐ Individual ☐ 2-Party (self plus one) ☐ Family_____

DEPENDENT INFORMATION

Complete this section only if you are applying for dependent coverage. List your legal spouse and dependent children, up to age 26. If additional space is required, please attach a separate sheet. Supporting documentation (birth certificate, adoption order, marriage license, divorce decree, etc.) is required for the addition of dependents. Dependents will not be added until the supporting document(s) are received by the Fund Office. 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 except in cases of Open Enrollment if applicable.

Name	SSN	Date of Birth	Sex	Relationship	Employment Status
					☐ No ☐ Yes If yes, indicate name of Employer: _____ Phone #: _____
					☐ No ☐ Yes If yes, indicate name of Employer: _____ Phone #: _____
					☐ No ☐ Yes If yes, indicate name of Employer: _____ Phone #: _____
					☐ No ☐ Yes If yes, indicate name of Employer: _____ Phone #: _____

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 MI

Address: (Complete if Beneficiary's address is not the same as the Member's) **Relationship:** _____

_____ _____ _____ _____
Street City State Zip

Name of Secondary Beneficiary: _____ _____ ____ **SSN:** _____
Last First MI

Address: (Complete if Beneficiary's address is not the same as the Member's) **Relationship:** _____

_____ _____ _____ _____
Street 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.

Signature_____ Date_____

Fund Office Use Only **Date Received:** _____ / _____/_____ **Date Entered:** _____ / _____/_____ **Entered By:** _____

THIS IS NOT AN APPLICATION FOR INSURANCE.