BENEFIT ENROLLMENT FORM
ASBESTOS WORKERS LOCAL UNION NO. 24 MEDICAL FUND
ASBESTOS WORKERS LOCAL UNION 24 PENSION FUND

7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046
Telephone: (410) 872-9500

Member Information

Name

Last _____ First _____ Init _____

Social Security Number ___-___-___

Address

Street _____ City _____ State _____ Zip _____

Telephone No. (_____) _____

Date of Birth ___/___/___ Mo. Day Yr.

Sex: Male ☐ Female ☐

Email: _____

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:		- -				Spouse
Dependent: (1)		- -				
(2)		- -				
(3)		- -				
(4)		- -				
(5)		- -				

ADDING OR DELETING DEPENDENTS

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 my death benefits according to my most recent beneficiary designation received in the Fund Office prior to my death.

Name of Primary Beneficiary SSN: _____

Last _____ First _____ Init _____ Relationship _____

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

Street _____ City _____ State _____ Zip _____

Name of Secondary Beneficiary SSN: _____

Last _____ First _____ Init _____ Relationship _____

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

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.

Date _____ Signature of Member _____

Fund Office Use Only

Date Received	Date Entered
Init	

Return original to Fund Office. Retain last copy for your records.