Local 807 Labor-Management Health Fund

32-43 49th Street, Long Island City, New York 11103

FOR OFFICIAL USE ONLY

Last Name _____ First Name _____ SS# _____

1. PRINT ALL INFORMATION IN INK ONLY - DO NOT FOLD CARD

Member Name (Last, First)	Member SS#	Date Of Birth	Sex	Married	Single

Address	Employer Name	Ledger No.

City	State	Zip Code	Home Phone Number	Marriage Date

Name Of Spouse	Spouse Social Security Number	Spouse Date of Birth

Is Your Husband/Wife Employed At Present? ☐ Yes ☐ No

If Yes, Name And Address Of Employer _____

_____

Phone Number: (_____)_____

Does Your Husband/Wife And/Or Children Have Health Insurance Or Other Coverage? ☐ Yes ☐ No

If Yes, Name And Address Of Insurance Co./Plan Name: _____

Policy Number/
Group Number: _____ Address: _____

2. Dependent Information

List dependents under age 19 only if they are natural children or legally adopted. List names in order of age - eldest first. In cases of adoption, you must supply copy of legal proof. If a dependent child has insurance coverage from other parent, give name, address and name and address of employer of other parent:

_____

_____

Dependents Name	Social Security Number	Check (✓) Relationship		Date of Birth		
		Son	Daughter	Month	Day	Year
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

This information may be used for purposes of updating my Union and Fund Office records. The statements set forth on the front and back of this enrollment card are to the best of my knowledge true and complete.

X _____

Member's Signature Date

Continued on Reverse Side

Email: _____

3. Members Beneficiary Information - Death Benefit

Insert name and address of person(s) to whom your Death Benefit is to be paid. State how the person(s) is related to you.
If a minor, state age and give name, address & relationship of guardian(s) below in "Remarks" section (5).
If more than one person is to share the Death Benefit, indicate below in "Remarks" section (5).

Last Name of Primary Beneficiary(ies)	First Name of Primary Beneficiary(ies)	Relationship to Member	Birth Date (If Under 18)
Street Address of Primary Beneficiary(ies)	City and State		Zip Code
Last Name of Secondary Beneficiary	First Name of Secondary Beneficiary	Relationship to Member	Birth Date (If Under 18)
Street Address of Secondary Beneficiary	City and State		Zip Code

4. Spouse's Beneficiary Information - Death Benefit

(This is a separate spousal Death Benefit and should be completed only by the Spouse and signed by the Spouse.)

Insert name and address of person(s) to whom your Death Benefit is to be paid. State how the person(s) is related to you.
If a minor, state age and give name, address & relationship of guardian(s) below in "Remarks" section (6).
If more than one person is to share the Death Benefit, indicate below in "Remarks" section (6).

Last Name of Primary Beneficiary(ies)	First Name of Primary Beneficiary(ies)	Relationship to Member	Birth Date (If Under 18)
Street Address of Primary Beneficiary(ies)	City and State		Zip Code
Last Name of Secondary Beneficiary	First Name of Secondary Beneficiary	Relationship to Member	Birth Date (If Under 18)
Street Address of Secondary Beneficiary	City and State		Zip Code

X _____

Spouse's Signature Date

5. Remarks:

6. Remarks:

7. FOR FUND OFFICE USE ONLY

Date of Enrollment

MEMBER INSURANCE RECORD