National Asbestos Workers Medical Fund

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Administered by:
NEBA

Enrollment Form

Section A. Demographic Information

Instructions: Please provide the demographic information requested.

Employee Name:		**Social Security #:**	
Date of Birth:		**Local Union #:**	
Gender:		**Email Address:**	
Mailing Address:		**Home Phone #:**	
City, State Zip:		**Cell Phone #:**	

Section B: Dependent Information

Instructions: Please provide the information requested for all dependents you wish to enroll in the Plan. Please refer to your Summary Plan Description for the definition of an eligible Dependent. Note that you must provide supporting documentation for all dependents being enrolled, such as a marriage certificate, birth certificate, adoption order, etc.

Name of Spouse	Date of Marriage	Social Security Number	Date of Birth	Gender

Name of Child	Relationship	Social Security Number	Date of Birth	Gender

Section C: Beneficiary Information

Instructions: Please name your primary beneficiary for death benefits available under the Plan. You may also name a secondary beneficiary in the event that your primary beneficiary is deceased at the time benefits would be payable.

Name of Beneficiary	Relationship	Social Security Number	Address	Beneficiary Type
				☐ Primary ☐ Secondary
				☐ Primary ☐ Secondary

Section D: Coordination of Benefits Information

Instructions: If you have enrolled your spouse or children in the Plan, please complete the following section pertaining to other medical or dental coverage in which they may be enrolled. If they are not enrolled in other coverage, mark None.

Name of Spouse	Other Coverages	Insurance Carrier Name	Insurance Carrier Phone #	Policy #
	☐ Medical			
	☐ Dental			
	☐ None			
Name of Child	**Other Coverages**	**Insurance Carrier Name**	**Insurance Carrier Phone #**	**Policy #**
	☐ Medical			
	☐ Dental			
	☐ None			
Name of Child	**Other Coverages**	**Insurance Carrier Name**	**Insurance Carrier Phone #**	**Policy #**
	☐ Medical			
	☐ Dental			
	☐ None			
Name of Child	**Other Coverages**	**Insurance Carrier Name**	**Insurance Carrier Phone #**	**Policy #**
	☐ Medical			
	☐ Dental			
	☐ None			
Name of Child	**Other Coverages**	**Insurance Carrier Name**	**Insurance Carrier Phone #**	**Policy #**
	☐ Medical			
	☐ Dental			
	☐ None			

Section E: Certification and Signature

I certify that the information provided on this enrollment form is true to the best of my knowledge and that the dependents I have enrolled meet the Plan's definition of Dependent, which can be found in the Summary Plan Description. I understand that it is my responsibility to notify the Plan Administrator within 60 days of a divorce or legal separation from my spouse. I acknowledge that the Plan requires me to reimburse the Plan if I or my dependent(s) 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 or for me or my dependent(s) in error.

Employee Signature: ____ **Date:** ______________________