LABORERS' BENEFITS • ST. LOUIS

MEMBER ENROLLMENT FORM

2357 59th Street • St. Louis, MO 63110 • (314) 644-2777
Fax: (314) 646-4440 • www.stllaborers.com • Email: benefits@stllaborers.com

Member Information:

SSN#: _____ DOB: _____ Local #: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

(C) Phone: _____ (W) Phone: _____

Email: _____ Sex: O F O M

Marital Status: O Single O Married O Separated O Divorced

Beneficiary: REQUIRED

Name: _____ DOB: _____

Relationship: _____ Phone: _____

O Primary O Contingent % of Assigned Benefit: _____

Address: _____

City: _____ State: _____ Zip: _____

To list additional beneficiary(ies), contact the Benefit Office.

This beneficiary designation applies to welfare (death), pension and vacation benefits, along with any Local Union death benefit unless you designate otherwise.

Please complete the back of the form if you are adding a spouse or dependent child(ren).

In order to activate coverage for any new eligible dependent you acquire, it is strongly recommended that you complete an enrollment form with respect to that new dependent and return it to the Benefit Office within 31 days after you acquire that dependent along with any required documentation. Coverage will be effective for that dependent retroactive to the date you acquired the new eligible dependent. You have 90 days after the birth of a child to provide a copy of the child's birth certificate. If you fail to submit a completed enrollment form or any required documentation other than a birth certificate within 31 days after you acquire a dependent or a birth certificate within 90 days after the birth of a child, coverage for that dependent will be effective the first of the month following receipt of the completed enrollment form, birth certificate or other required documentation, as applicable.

I/We certify the above information is true, complete and accurate to be best of my/our knowledge. I/We hereby authorize any physician, hospital, employer, insurance company, or other institution rendering care to furnish the Laborers' Welfare Fund with information regarding benefits to which I/We may be entitled. A photocopy of this authorization shall be considered as effective and valid as the original.

Member Signature: _____ Spouse Signature: _____ Date: _____

Spouse Information:

Name: _____ SS#: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____ Sex: ○ F ○ M

Date of Marriage: _____ Do you live with the member? ○ Yes ○ No

Employer Name: _____ Do you have other insurance coverage? ○ Yes ○ No

Dependent Information: Complete the following information on all children less than 26 years of age.

Name	Relationship	Date of Birth	SSN#	Do you have other insurance coverage?
				○ Yes ○ No
				○ Yes ○ No
				○ Yes ○ No
				○ Yes ○ No
				○ Yes ○ No
				○ Yes ○ No
				○ Yes ○ No