LIFE INSURANCE ENROLLMENT

Important Instructions for Completing Your Enrollment Form

You do not need to complete the “Policy Holder Information” or “Insurance Amount” sections. These sections will be completed by Laborers’ Local 265 on your behalf.

Returning Your Completed Form

Once you have completed the form, please return it to:

Laborers’ Local 265

3457 Montgomery Road

Cincinnati, OH 45207

Thank you for taking the time to complete your enrollment!

THE UNION LABOR LIFE INSURANCE COMPANY

ENROLLMENT AND BENEFICIARY FORM

Please submit this form to:
Group Life Claims Department
The Union Labor Life Insurance Company
7373 Wisconsin Ave Ste 2000 • Bethesda MD 20814
Toll free: 866-795-0680 • Fax: 202-962-2939
LifeClaims@ullico.com

This form is to be utilized for enrollment and beneficiary purposes only. All correspondence and questions should be addressed to the Fund/Employer maintaining your eligibility information.

- For all new additions and reinstatements, complete the entire form, and sign at the bottom.
- For all other needs, complete the appropriate section, and sign at the bottom.

Please check: ☐ **New Enrollment** ☐ **Reinstatement** ☐ **Address Change** ☐ **Beneficiary Change**

POLICYHOLDER INFORMATION

Name of Policyholder: _____

Group Policy Number: _____ Effective Date: _____ Local/Bill ID: _____

INSURANCE AMOUNT

☐ Duplicate certificate request

	Life	AD&D	AH	LTD
Amount	$	$	$	$
Billing Classes				

MEMBER INFORMATION

Please make certain all questions are answered and proper supporting documents are attached

Full Name: _____ _____ _____
Last First Middle

☐ Male ☐ Female ☐ Active ☐ Retiree Date of Birth: _____ SSN: _____ - ____ - _____

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

Occupation: _____ Date started working: _____ Weekly Earnings: _____

BENEFICIARY INFORMATION

If the beneficiary is changing, the new beneficiary will replace all prior designations and will be effective as of the date this form is signed.

		Beneficiary Name	Relationship to Member	Date of Birth	% of Share	SSN:
Primary:	1				%	
	2				%	
	3				%	
	4				%	
Contingent:	1				%	
	2				%	

If additional space is needed, please use a separate piece of paper and attach it to this form.

Member Signature: _____ Date: _____
(Required)

Witness Signature: _____ Date: _____
(Required for new adds, reinstatements or beneficiary change)
Note: Witness cannot be a primary or contingent beneficiary listed above