Solutions for the Union Workforce

Enrollment/Beneficiary Form

(PLEASE PRINT)

Send Form: Laborers' Local 265

3457 Montgomery Rd, Cinti, OH 45207

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

Please check: ◻ New enrollment ◻ Reinstatement ◻ Address Change ◻ Beneficiary Change

Policyholder Information:

Name of group policyholder: LABORERS' LOCAL 265 Policy Number: G 3309 C4572
Effective Date: November 1, 2017 Local /Bill ID: Laborers' Local 265

Insured/Member Information: Please check 1 of each: ◻Male OR ◻Female AND ◻Active OR ◻Retired

Name of insured____

Last Name First Name Middle Name

Address:____

City_______________________________________State________________Zip__________________

Social Security Number____Date of Birth______/______/______

BENEFICIARY: Note: If the beneficiary is being changed, the new beneficiary will replace all prior designations and will be effective as of the date this form is signed.

Beneficiary Name Relationship to Insured DOB % share SSN

A) Primary:

1.______________________________/__________________/_____________/__________/___________________

2.______________________________/____________________/_____________/__________/___________________

B) Contingent:

1.__________________________/____________________/_____________/__________/___________________

2.__________________________/____________________/_____________/__________/___________________

Insured Signature:____Date_____________________

**Witness Signature:____Date_____________________

Witness CANNOT be the Beneficiary