

NYC District Council of Carpenters Welfare Fund/Pension Fund

Enrollment/Beneficiary Designation Form

Participant Information:

Name:	Social Security Number:	UBC Number:
Mailing Address:		
Home Phone:	Cell Phone:	Date of Birth:
Email Address:		
Emergency Contact Name:	Emergency Cell Phone:	Emergency Email Address:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed <i>*If you are divorced, it is your responsibility to notify the Fund Office to disenroll your ex-spouse from coverage immediately. Otherwise you will be financially liable for any amounts/claims paid in error and you may lose your coverage under the Fund.</i>		

Dependent(s) Information

List **SPOUSE** whom you wish to enroll and attach photocopies of marriage certificate and Social Security card. Include proof of Spouse's date of birth if not indicated on marriage certificate. Please include a photocopy of his/her Medicare card, if applicable.

First Name	Last Name	Gender M/F	Social Security Number	Date of Birth	Medicare Y/N?

List **DEPENDENT CHILDREN** and attach photocopy of birth certificate and social security card for each child. Please include copy of Medicare card, if applicable. Additional information may be required.

First Name	Last Name	Gender M/F	Social Security Number	Date of Birth	Medicare Y/N?

CERTIFICATION: I hereby certify that I have read the above information and that the information herein, pertaining to dependent(s)' health coverage and/or beneficiary designations upon my death, is correct/true to the best of my knowledge. I understand that I may change/add health coverage dependent(s) and/or beneficiary designations at any time. I understand that if I improperly enroll a dependent for coverage under the Fund or fail to timely notify the Fund if a dependent becomes ineligible for coverage, for example, if I become divorced, I will be responsible for reimbursing the Fund for the cost of any claims or premiums paid in error for the ineligible individual and I may also have my coverage and the coverage of any other eligible dependents terminated.

PARTICIPANT SIGNATURE

DATE SIGNED

Please sign and date this form and return it to the Fund Office
 NYCDCC Welfare Fund
 395 Hudson Street
 New York, New York 10014
 Attention: Welfare Department

Beneficiary Designation

*To designate, revoke, or change a beneficiary, please complete, sign, and date this Beneficiary Designation Form. Please ensure that the designated percentage of benefits is equal to 100% **for EACH category- Primary and Secondary**. **NOTE:** Secondary Beneficiary will be eligible **ONLY** if all your Primary Beneficiaries predecease you. ☐ To designate additional beneficiaries, please check the box and print another form to list the names.

Primary Beneficiary Information

Full Name: _____	Social Security Number: _____
Relationship to You: _____	Date of Birth: _____
Mailing Address: _____	City _____ State _____ Zip _____
Home Phone: _____	Cell Phone: _____
Email Address: _____	% of Benefit: _____

Primary Beneficiary Information

Full Name: _____	Social Security Number: _____
Relationship to You: _____	Date of Birth: _____
Mailing Address: _____	City _____ State _____ Zip _____
Home Phone: _____	Cell Phone: _____
Email Address: _____	% of Benefit: _____

Secondary Beneficiary Information

Full Name: _____	Social Security Number: _____
Relationship to You: _____	Date of Birth: _____
Mailing Address: _____	City _____ State _____ Zip _____
Home Phone: _____	Cell Phone: _____
Email Address: _____	% of Benefit: _____

Secondary Beneficiary Information

Full Name: _____	Social Security Number: _____
Relationship to You: _____	Date of Birth: _____
Mailing Address: _____	City _____ State _____ Zip _____
Home Phone: _____	Cell Phone: _____
Email Address: _____	% of Benefit: _____

CERTIFICATION: I hereby certify that I have read the above information and that the information herein, pertaining to dependent(s)' health coverage and/or beneficiary designations upon my death, is correct/true to the best of my knowledge. I further understand that I may change/add health coverage dependent(s) and/or beneficiary designations at any time.

PARTICIPANT NAME (PRINT)

UBC #

PARTICIPANT SIGNATURE

DATE SIGNED