



1 LAST NAME										FIRST NAME										M.I.	
STREET ADDRESS															APT NO.						
CITY										STATE		ZIP									
SOCIAL SECURITY NUMBER					HOME PHONE NUMBER					DATE OF BIRTH											
E-MAIL ADDRESS																					

2 TYPE OF APPLICATION OR CHANGE

- New application Add family member Remove family member Change of address Name change

Complete applicable information in Section 6 on the other side of this form

REASON FOR CHANGE

- Marriage Divorce Birth Death Other (specify) _____ Date of event _____

If removing a family member, please provide his/her current address

Name	Address	City, State, ZIP
------	---------	------------------

3 PERSONS TO BE COVERED (For additional dependents attach a separate list if necessary)

Attach a copy of a birth certificate or adoption papers for each child to be covered
Attach a copy of your marriage certificate when your spouse is to be covered

ADD	REMOVE	CONTINUE	NAME (Include last name if different from applicant)	SEX	DATE OF BIRTH MO DAY YEAR	SOCIAL SECURITY NUMBER	RELATIONSHIP TO YOU
			SELF	<input type="checkbox"/> M <input type="checkbox"/> F	-- --	-- --	N/A
			SPOUSE	<input type="checkbox"/> M <input type="checkbox"/> F	-- --	-- --	N/A
				<input type="checkbox"/> M <input type="checkbox"/> F	-- --	-- --	
				<input type="checkbox"/> M <input type="checkbox"/> F	-- --	-- --	
				<input type="checkbox"/> M <input type="checkbox"/> F	-- --	-- --	

4 COVERAGE INFORMATION

Is your husband/wife employed at present? Yes No If yes, is employment Full time or Part time If spouse is employed, please provide name, address and telephone of employer below

Name	Address	City, State, ZIP	Telephone
------	---------	------------------	-----------

Does your husband/wife/dependent children have health insurance or other coverage? Yes No If yes, please provide name and policy/group number of insurance company/plan below:

Name of insurance company/plan	Policy/group number	Effective date of coverage
--------------------------------	---------------------	----------------------------

Does your husband/wife/dependent children have dental insurance? Yes No If yes, please provide name and policy/group number of insurance company/plan below:

Name of insurance company/plan	Policy/group number	Effective date of coverage
--------------------------------	---------------------	----------------------------

Does your husband/wife/dependent children have prescription insurance? Yes No If yes please provide name and policy/group number of insurance company/plan below:

Name of insurance company/plan	Policy/group number	Effective date of coverage
--------------------------------	---------------------	----------------------------

5 EMPLOYMENT INFORMATION

At which 1199 institution do you now work? _____ Work starting date _____ Full time or Part time Hours per week _____

Your employer's address _____

City _____ State _____ ZIP _____

Do you have a second job at another 1199 institution? Yes No If yes, please provide the information requested below:

At which 1199 institution do you now work? _____ Work starting date _____ Full time or Part time Hours per week _____

Your employer's address _____

City _____ State _____ ZIP _____

Please turn this page over and complete the information on the other side.

6 CHANGE INFORMATION

NAME CHANGE (enter former name, last name first, and attach marriage certificate or other document which gives proof of legal name change)		FIRST NAME		MI
WRONG SSN (attach copy of Social Security card)		IF YOU REGISTERED CHILDREN IN SECTION 4 ON THE OTHER SIDE, INCLUDE A BIRTH CERTIFICATE FOR EACH CHILD YOU REGISTERED.		
NEW SPOUSE <input type="checkbox"/> WIFE or <input type="checkbox"/> HUSBAND (enter last name first)		FIRST NAME		MI
SPOUSE SOCIAL SECURITY NUMBER	SPOUSE DATE OF BIRTH	DATE OF MARRIAGE	ATTACH COPY OF MARRIAGE CERTIFICATE	
NEW CHILD <input type="checkbox"/> SON or <input type="checkbox"/> DAUGHTER (enter last name first)		FIRST NAME		MI
CHILD'S SOCIAL SECURITY NUMBER	CHILD'S DATE OF BIRTH	Is your child covered by health insurance other than the Benefit Fund? <input type="checkbox"/> YES or <input type="checkbox"/> NO		ATTACH BIRTH CERTIFICATE OR ADOPTION PAPERS
If your child is covered by other health insurance what type of coverage does s/he have? (check all that apply)		Name of Insurance Company or Plan		
<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Hospitalization <input type="checkbox"/> Prescription <input type="checkbox"/> Vision <input type="checkbox"/> Major Medical		Policy No. _____ Group No. _____ Effective date of coverage _____		
NEW ADDRESS				APT. NO.
CITY	STATE	ZIP	NEW HOME PHONE NUMBER () - -	

NEW EMPLOYER

Name of new employer _____ Work starting date _____ Full time or Part time Hours per week _____

Your employer's address _____

City _____ State _____ ZIP _____

Name of former employer _____ Last date of work for former employer _____

7 BENEFICIARY INFORMATION — DEATH BENEFIT

Below, please name the person(s) to whom your Death Benefit is to be paid. Please provide ALL requested information. If your beneficiary is a minor, state her/his age and provide the name(s) of the person(s) parent(s) or guardian(s) in the "Remarks" section below. You may name more than one person to share the Death Benefit. Should you choose to do this, indicate the percentage each individual is to receive in the "Remarks" section below and indicate that ALL of your named beneficiaries are primary beneficiaries. Any person named as a secondary beneficiary will receive benefits only if the primary beneficiary dies before you.

PRIMARY BENEFICIARY INFORMATION

LAST NAME	FIRST NAME	MI	RELATIONSHIP OF THIS PERSON TO YOU	
STREET ADDRESS			APT. NO.	
CITY	STATE	ZIP		
SOCIAL SECURITY NUMBER	HOME PHONE NUMBER () - -	DATE OF BIRTH	AGE	

SECONDARY BENEFICIARY INFORMATION

LAST NAME	FIRST NAME	MI	RELATIONSHIP OF THIS PERSON TO YOU	
STREET ADDRESS			APT. NO.	
CITY	STATE	ZIP		
SOCIAL SECURITY NUMBER	HOME PHONE NUMBER () - -	DATE OF BIRTH	AGE	

8 REMARKS

Failure to sign and date this form or to provide any required documentation may delay processing of this form and thereby delay coverage for you and/or your dependent(s).

9 The foregoing statements are, to the best of my knowledge, true and complete. This information may be used for purposes of updating my Union records.

MEMBER'S SIGNATURE _____ TODAY'S DATE _____

**PLEASE RETURN THIS FORM TO THE BENEFIT FUND
1319 LOCUST STREET · PHILADELPHIA, PA 19107**