



Chicago Regional Council of Carpenters Welfare Fund
 12 E. Erie Street – Chicago, IL 60611
 (312) 787-9455, Phone Option 3



Enrollment and Life Insurance Beneficiary Designation Form

Instructions: Print Clearly in Ink. You must complete the form in full, sign and return it along with your certified marriage license and certified birth certificates for your dependents, if applicable, in the enclosed self-addressed envelope. All documents will be returned to you.

| | | | | | | | | | | | |
|-------------------------|-----|------|--|---|----------------|---------------------|-------------|--|--------------------|--|--|
| Participant's Last Name | | | First Name in Full | | | Middle Name in Full | | | | | |
| Date Of Birth | | | Gender | | Marital Status | | | Social Security # or Individual Tax ID # (ITIN) | | | |
| MONTH | DAY | YEAR | <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | | - - | | | | |
| Home Address | | | | | | | Apt. Number | | | | |
| City | | | | | | | State | | Zip Code + Zip Ext | | |
| Home Phone Number | | | Cell Phone Number | | | Email Address | | | | | |
| () - | | | () - | | | | | | | | |

Print name of each dependent below. Dependents that may be included are your spouse and all unmarried children under age 19 (or up to age 23 if a full time student). All dependents must be listed. **To add dependents to your medical coverage you are required to send an Original/Certified Marriage License and Original/Certified Birth Certificates for Dependents.** Original documents will be returned to you.

| First and Last Name of Spouse and Eligible Dependents | Birth Date | | | Relationship to Participant |
|---|------------|-----|------|---|
| | Month | Day | Year | |
| | | | | <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain Other: |
| | | | | <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain Other: |
| | | | | <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain Other: |
| | | | | <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain Other: |
| | | | | <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain Other: |
| | | | | <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain Other: |
| | | | | <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain Other: |

| | | | | | | | |
|--|-----|--------------------|----------------------------|--|--|--|--------------------|
| CATEGORY | | | | Explain Category Other: | | | |
| <input type="checkbox"/> Journeyman <input type="checkbox"/> Apprentice <input type="checkbox"/> Other | | | | | | | |
| PRESENT LOCAL UNION | | | | Is your present Local your <u>First</u> Local in the Chicago Regional Council? | | My <u>First</u> Local Union in the Chicago Regional Council was: | |
| Since | | Local Union Number | Member's Union I.D. Number | | | Initiation Date | Local Union Number |
| MONTH | DAY | YEAR | | | | Month | Year |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No - If no, complete next section | | | |

Statement: It is fraudulent to fill out this form with information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the above information is untrue, I agree to reimburse the Chicago Regional Council of Carpenters Welfare Fund for any money it was induced to pay as a result of the information I provided. Receipt of this form is not a guarantee of eligibility.

| | | | | | | | | |
|------------------|---------------------------------|--|--|--|--|-------------|-----|------|
| Sign Here | Participant's Signature in Full | | | | | Date Signed | | |
| | | | | | | Month | Day | Year |

(Over for Designation of Life Insurance Beneficiary)

Designation of Life Insurance Beneficiary

Instructions: **Print Clearly in Ink.** If more than one beneficiary is designated, the designated beneficiaries will share equally. If any designated beneficiary dies before the Participant, the share that such beneficiary would have received if he/she had survived the Participant's death will be payable equally to the remaining designated beneficiaries who survive the Participant. The following information is required for each beneficiary.

- Beneficiary's full name (e.g. Mary B. Jones, not Mrs. John J. Jones);
- Relationship to Participant (if not related to Participant, show as %friend+); and
- Address, Birth date, and Social Security Number. Note if a SS# or ITIN is not provided, it may be difficult to locate a beneficiary should their address change.

A Participant should review his/her beneficiary designation when the Participant's marital status changes, the Participant has a child, or the Participant experiences another major life event.

In the event of my death, my life insurance benefit should be paid to:

| | | | | | |
|-------------------------------|--|---------------------------|-----------|----------------------------|-----|
| Beneficiary's First Name | | M.I. | Last Name | | |
| Relationship to Participant | | Birth Date of Beneficiary | | SS# or ITIN of Beneficiary | |
| Street Address of Beneficiary | | | City | State | Zip |
| Beneficiary's First Name | | M.I. | Last Name | | |
| Relationship to Participant | | Birth Date of Beneficiary | | SS# or ITIN of Beneficiary | |
| Street Address of Beneficiary | | | City | State | Zip |
| Beneficiary's First Name | | M.I. | Last Name | | |
| Relationship to Participant | | Birth Date of Beneficiary | | SS# or ITIN of Beneficiary | |
| Street Address of Beneficiary | | | City | State | Zip |
| Beneficiary's First Name | | M.I. | Last Name | | |
| Relationship to Participant | | Birth Date of Beneficiary | | SS# or ITIN of Beneficiary | |
| Street Address of Beneficiary | | | City | State | Zip |
| Beneficiary's First Name | | M.I. | Last Name | | |
| Relationship to Participant | | Birth Date of Beneficiary | | SS# or ITIN of Beneficiary | |
| Street Address of Beneficiary | | | City | State | Zip |

I hereby revoke any and all previous life insurance beneficiary designations and hereby designate the above as my beneficiary(ies). I understand that I may change my beneficiary designation(s) at any time by completing an Enrollment and Life Insurance Beneficiary Designation Form. Such change shall become effective when the form is received by the Chicago Regional Council of Carpenters Welfare Fund Office.

| | | | | | | |
|------------------|---------------------------------|--|--|-------------|-----|------|
| Sign Here | Participant's Signature in Full | | | Date Signed | | |
| | | | | Month | Day | Year |

For Office Use Only

| | | |
|---------------------------------------|--|--------------------------------------|
| Contributions Dept. (Date & Initials) | Participant Services Dept. (Date & Initials) | Apprentice School. (Date & Initials) |
| | | |