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:		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ***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.***		

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**