LABORERS LOCAL NO. 754 JOINT BENEFIT FUNDS
215 OLD NYACK TURNPIKE • CHESTNUT RIDGE, NY 10977
PHONE 845-425-0210 FAX 845-425-1835

TO: **ALL LABORERS LOCAL NO. 754 PARTICIPANTS** DATE:

YOUR IMMEDIATE COOPERATION IS REQUESTED IN COMPLETING THIS DATA SPECIFICALLY DESIGNED FOR THE PROTECTION OF YOUR BENEFITS. THIS WILL BE YOUR PERMANENT RECORD SO BE SURE THAT YOU ANSWER ALL QUESTIONS. RETURN THE COMPLETED FORM TO THE FUND OFFICE. UPDATE AS NEEDED. PLEASE COMPLETE THE FORM IN ITS ENTIRETY WHETHER OR NOT YOU ARE PARTICIPATING IN ALL THE FUNDS LISTED.

BENEFICIARY FORM PARTICIPANT INFORMATION

Please Print

NAME (**MEMBER**)_____
LAST FIRST MIDDLE INITIAL

ADDRESS_____

_____ZIP_____

SOCIAL SECURITY NO._____DATE OF BIRTH_____

TELEPHONE NO._____CELL NO._____E-MAIL ADDRESS_____

SEX [ ] MALE [ ] FEMALE

MARITAL STATUS [ ] SINGLE [ ] MARRIED [ ] LEGALLY SEPARTED *(Provide Documents)* [ ] WIDOWED [ ] DIVORCED *(Provide Documents)*

EFFECTIVE DATE OF CURRENT STATUS:_____

WELFARE-BENEFICIARY NAME_____**SOCIAL SECURITY NO.:**_____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

SAVINGS-BENEFICIARY NAME_____**SOCIAL SECURITY NO.:**_____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

***PENSION-BENEFICIARY NAME**_____**SOCIAL SECURITY NO.:**_____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

***ANNUITY-BENEFICIARY NAME**_____**SOCIAL SECURITY NO.:**_____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

***IF YOU ARE MARRIED, YOU MUST DESIGNATE YOUR SPOUSE. IN ACCORDANCE WITH FEDERAL LAW, IF YOU ARE A VESTED PARTICIPANT UNDER THE PENSION PLAN AND/OR ANNUITY PLAN, "BENEFICIARY" MEANS YOUR LAWFUL SPOUSE OR, IF THERE IS NO LAWFUL SPOUSE, THE PERSON YOU SPECIFY IN WRITING AS YOUR DESIGNATED BENEFICIARY.**

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT ANY FALSE INFORMATION MAY DISQUALIFY ME FOR BENEFITS AND THAT THE FUNDS SHALL HAVE THE RIGHT TO RECOVER ANY BENEFIT PAYMENTS MADE BECAUSE OF FALSE INFORMATION.

PARTICIPANT SIGNATURE _____**DATE**_____

SPOUSE SIGNATURE _____**DATE**_____

FOR SPOUSE LISTED YOU MUST ATTACH A COPY OF THE CERTIFICATE OF MARRIAGE, IF IT IS NOT ON RECORD WITH THE FUND OFFICE ALREADY. FOR EACH DEPENDENT CHILD LISTED YOU MUST ATTACH A COPY OF THE BIRTH CERTIFICATE NAMING YOU AS THE PARENT OF SUCH CHILD. IF YOU ARE NOT THE PARENT OF DEPENDENT CHILD LISTED BELOW, ATTACH A COPY OF THE COURT ORDER OF ADOPTION OR A COURT ORDER DESIGNATING YOU AS GUARDIAN, IF IT IS NOT ON RECORD WITH THE FUND OFFICE ALREADY.

SPOUSE INFORMATION

SPOUSE NAME_____ [ ] WIFE [ ] HUSBAND

SOCIAL SECURITY NO._____ DATE OF BIRTH_____

DO YOU OR YOUR SPOUSE NOW HAVE ANY **OTHER** HEALTH COVERAGE? [ ] YES [ ] NO

IF YES, PLEASE COMPLETE THE ATTACHED MERITAIN OTHER INSURANCE COVERAGE INFORMATION FORM AND RETURN IT TO LABORERS LOCAL NO. 754 FUND OFFICE.

IS SPOUSE EMPLOYED? [ ] YES [ ] NO [ ] PART TIME [ ] FULL TIME [ ] RETIRED

DOES SPOUSE'S EMPLOYER OFFER HEALTH COVERAGE? [ ] YES [ ] NO

NAME OF EMPLOYER_____

ADDRESS_____

HEALTH INSURANCE SPOUSE HAS AT PLACE OF EMPLOYMENT_____

_____

DID SPOUSE EVER HAVE INSURANCE COVERAGE THROUGH EMPLOYER? [ ] YES [ ] NO

HAS SPOUSE ELECTED TO WAIVE COVERAGE WITH EMPLOYER? [ ] YES [ ] NO

IF YES, EXPLAIN_____

_____

IS INSURED MEMBER AND/OR SPOUSE COVERED BY MEDICARE? [ ] MEMBER [ ] SPOUSE

EFFECTIVE DATE FOR MEDICARE: MEMBER_____ SPOUSE_____

PLEASE PROVIDE A COPY OF THE MEDICARE CARD FOR OUR FILES

DEPENDENT CHILD INFORMATION

CHILD NAME_____ DATE OF BIRTH_____ RELATIONSHIP_____

SOCIAL SECURITY NO._____ DOES CHILD LIVE WITH YOU? [ ] YES [ ] NO
(IF NO PLEASE PROVIDE ADDRESS BELOW)

_____

DOES CHILD HAVE OTHER INSURANCE? [ ] YES [ ] NO
IF YES, PLEASE COMPLETE THE ATTACHED MERITAIN OTHER INSURANCE COVERAGE INFORMATION FORM AND RETURN IT TO LABORERS LOCAL NO. 754 FUND OFFICE.

DEPENDENT CHILD INFORMATION CONTINUED

CHILD NAME________________________________DATE OF BIRTH___________________RELATIONSHIP______________

SOCIAL SECURITY NO.__________________________DOES CHILD LIVE WITH YOU? [ ] YES [ ] NO
(IF NO PLEASE PROVIDE ADDRESS BELOW)

____

DOES CHILD HAVE OTHER INSURANCE? [ ] YES [ ] NO
IF YES, PLEASE COMPLETE THE ATTACHED MERITAIN OTHER INSURANCE COVERAGE INFORMATION FORM AND RETURN IT TO LABORERS LOCAL NO. 754 FUND OFFICE.

CHILD NAME________________________________DATE OF BIRTH___________________RELATIONSHIP______________

SOCIAL SECURITY NO.__________________________DOES CHILD LIVE WITH YOU? [ ] YES [ ] NO
(IF NO PLEASE PROVIDE ADDRESS BELOW)

____

DOES CHILD HAVE OTHER INSURANCE? [ ] YES [ ] NO
IF YES, PLEASE COMPLETE THE ATTACHED MERITAIN OTHER INSURANCE COVERAGE INFORMATION FORM AND RETURN IT TO LABORERS LOCAL NO. 754 FUND OFFICE.

CHILD NAME________________________________DATE OF BIRTH___________________RELATIONSHIP______________

SOCIAL SECURITY NO.__________________________DOES CHILD LIVE WITH YOU? [ ] YES [ ] NO
(IF NO PLEASE PROVIDE ADDRESS BELOW)

____

DOES CHILD HAVE OTHER INSURANCE? [ ] YES [ ] NO
IF YES, PLEASE COMPLETE THE ATTACHED MERITAIN OTHER INSURANCE COVERAGE INFORMATION FORM AND RETURN IT TO LABORERS LOCAL NO. 754 FUND OFFICE.

CHILD NAME________________________________DATE OF BIRTH___________________RELATIONSHIP______________

SOCIAL SECURITY NO.__________________________DOES CHILD LIVE WITH YOU? [ ] YES [ ] NO
(IF NO PLEASE PROVIDE ADDRESS BELOW)

____

DOES CHILD HAVE OTHER INSURANCE? [ ] YES [ ] NO
IF YES, PLEASE COMPLETE THE ATTACHED MERITAIN OTHER INSURANCE COVERAGE INFORMATION FORM AND RETURN IT TO LABORERS LOCAL NO. 754 FUND OFFICE.

CHILD NAME________________________________DATE OF BIRTH___________________RELATIONSHIP______________

SOCIAL SECURITY NO.__________________________DOES CHILD LIVE WITH YOU? [ ] YES [ ] NO
(IF NO PLEASE PROVIDE ADDRESS BELOW)

____

DOES CHILD HAVE OTHER INSURANCE? [ ] YES [ ] NO
IF YES, PLEASE COMPLETE THE ATTACHED MERITAIN OTHER INSURANCE COVERAGE INFORMATION FORM AND RETURN IT TO LABORERS LOCAL NO. 754 FUND OFFICE.

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IF YOU WOULD LIKE TO ASSIGN CONTINGENT BENEFICIARIES PLEASE COMPLETE THE FOLLOWING
(This Form will be invalid without a completed Beneficiary Form)

CONTINGENCY BENEFICIARY FORM

Please Print

CONTINGENT WELFARE-BENEFICIARY NAME_____SOCIAL SECURITY NO._____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

CONTINGENT SAVINGS-BENEFICIARY NAME_____SOCIAL SECURITY NO._____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

CONTINGENT PENSION-BENEFICIARY NAME_____SOCIAL SECURITY NO._____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

CONTINGENT ANNUITY-BENEFICIARY NAME_____SOCIAL SECURITY NO._____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT ANY FALSE INFORMATION MAY DISQUALIFY ME FOR BENEFITS AND THAT THE FUNDS SHALL HAVE THE RIGHT TO RECOVER ANY BENEFIT PAYMENTS MADE BECAUSE OF FALSE INFORMATION.

PARTICIPANT SIGNATURE_____**DATE**_____

SPOUSE SIGNATURE_____**DATE**_____

Please complete multiple forms for multiple Contingent Beneficiaries

Other Insurance Coverage Information

We are asking for your help in getting information on other Medical/Dental insurance coverage currently in effect for you or your dependents. This information will expedite claims processing and enhance your level of service. **If we do not receive this information, it may delay the processing and payment of your claims.**

PLEASE PRINT:	
EMPLOYEE NAME	SOCIAL SECURITY NUMBER
NAME OF COMPANY (YOUR EMPLOYER):	

DO YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER COVERAGE IN EFFECT AT THIS TIME?

MEDICAL: ❑YES ❑NO
DENTAL: ❑YES ❑NO
MEDICARE: ❑YES ❑NO

If you answered **NO** for all of the above, please return this form to the Fund Office. If you answered **YES** to any of the above, please provide the information below & return to the Fund Office.

MEDICAL	
NAME OF INSURANCE COMPANY	NAME OF POLICY HOLDER
DATE OF BIRTH	EFFECTIVE DATE OF COVERAGE
PLEASE LIST **ALL** FAMILY MEMBERS COVERED BY THIS PLAN.	

DENTAL	
NAME OF INSURANCE COMPANY	NAME OF POLICY HOLDER
DATE OF BIRTH	EFFECTIVE DATE OF COVERAGE
PLEASE LIST **ALL** FAMILY MEMBERS COVERED BY THIS PLAN.	

MEDICARE		
DO YOU OR YOUR DEPENDENTS CURRENTLY HAVE MEDICARE COVERAGE? ❑ YES ❑ NO **IF YES, COMPLETE THE REST OF THIS SECTION.**		
NAME OF PERSONS COVERED BY MEDICARE	IF YOU OR YOUR SPOUSE ARE RETIRED, LIST NAME AND DATE OF RETIREMENT	
REASON FOR MEDICARE ELIGIBILITY: ❑ OVER AGE 65 ❑ END-STAGE RENAL DISEASE ❑ TOTAL DISABILITY		
PART A EFFECTIVE DATE(S)	PART B EFFECTIVE DATE(S)	PART D EFFECTIVE DATE(S)

OTHER COVERAGE	
IS THERE OTHER COVERAGE FOR YOUR CHILDREN DUE TO A COURT DECREE? ❑ YES ❑ NO	
IF YES, NAME OF PARENT(S) WITH LEGAL CUSTODY OF CHILDREN	ADDRESS OF PARENT(S) WITH LEGAL CUSTODY
IS THERE A COURT ORDER MAKING THE NONCUSTODIAL PARENT RESPONSIBLE FOR THE CHILDREN'S MEDICAL/DENTAL EXPENSES? ❑ YES ❑ NO IF YES, SUPPLY A COPY OF THE LEGAL DOCUMENTATION OF THIS DECISION.	
FAILURE TO PROVIDE THIS INFORMATION WILL RESULT IN DENIAL OF CLAIMS SUBMITTED BY YOU AND YOUR FAMILY MEMBERS.	