



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 MM-DD-YYYY

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

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

**3 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
--------------------------------	---------------------	----------------------------

**4 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	If current patient, check box beside physician name		
								LAST	FIRST	PRIMARY CARE PHYSICIAN NUMBER
			SELF	<input type="checkbox"/> M <input type="checkbox"/> F	-- --	-- --	N/A			<input type="checkbox"/>
			SPOUSE	<input type="checkbox"/> M <input type="checkbox"/> F	-- --	-- --	N/A			<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	-- --	-- --				<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	-- --	-- --				<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	-- --	-- --				<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	-- --	-- --				<input type="checkbox"/>

**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		M.I.
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		M.I.
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		M.I.
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) <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		Name of Insurance Company or Plan _____ 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		M.I.	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		M.I.	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**