District Council 37 Health & Benefit Fund

420 West 45th Street, 3rd Floor, New York, NY 10036
Tel.: (212) 334-0096 Fax: (212) 274-0104

Enrollment Form

Member's Information *(Please Print or Type)*

LastName:	First Name:	M.I.:
Mailing Address : ***Street***		***Apartment***
City	***State***	***Zip***
Soc. Sec. No.:	Birth Date:	Gender:
Phone Number:	Email:	
Relationship: ***Member***	Do you want Family Coverage? YES / NO	
Marital Status: [ ] Single	[ ] Married *(Date:)*	[ ] Divorced [ ] Widowed
Agency / Employer:		Hire Date:
Are you currently covered through another medical plan? YES / NO		Is this Family Coverage? YES / NO
If "YES", Name of Insurance:		Policy ID:
Effective Date:	Termination Date:	Is this COBRA Coverage? YES / NO

Spouse's Information *(Please Print or Type)*

LastName:	First Name:	M.I.:
Address: *(If different from Member's address)*		
Soc. Sec. No.:	Birth Date:	Phone No.:
Gender:	Relationship:	Is your spouse currently employed? YES / NO
Current Employer:	Hire Date:	Phone No.:
Is your spouse currently covered through another medical plan? YES / NO		Is this Family Coverage? YES / NO
If "YES", Name of Insurance:		Policy ID:
Effective Date:	Termination Date:	Is this COBRA Coverage? YES / NO

Dependent Child's Information *(Please Print or Type)*

1st	LastName:	First Name:	M.I.:
	Address: *(If different from Member's address)*		
Soc. Sec. No.:		Birth Date:	Phone No.:
Gender:	Relationship:		Is this dependent currently employed? YES / NO
Current Employer:		Hire Date:	Phone No.:
Is this dependent currently covered through another medical plan? YES / NO			Is this Family Coverage? YES / NO
If "YES", Name of Insurance:			Policy ID:
Effective Date:	Termination Date:		Is this COBRA Coverage? YES / NO

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Dependent Child's Information *(Please Print or Type)*

2nd

LastName: First Name: M.I.:

Address: *(If different from Member's address)*

Soc. Sec. No.: Birth Date: Phone No.:

Gender: Relationship: Is this dependent currently employed? YES / NO

Current Employer: Hire Date: Phone No.:

Is this dependent currently covered through another medical plan? YES / NO Is this Family Coverage? YES / NO

If "YES", Name of Insurance: Policy ID:

Effective Date: Termination Date: Is this COBRA Coverage? YES / NO

3rd

LastName: First Name: M.I.:

Address: *(If different from Member's address)*

Soc. Sec. No.: Birth Date: Phone No.:

Gender: Relationship: Is this dependent currently employed? YES / NO

Current Employer: Hire Date: Phone No.:

Is this dependent currently covered through another medical plan? YES / NO Is this Family Coverage? YES / NO

If "YES", Name of Insurance: Policy ID:

Effective Date: Termination Date: Is this COBRA Coverage? YES / NO

4th

LastName: First Name: M.I.:

Address: *(If different from Member's address)*

Soc. Sec. No.: Birth Date: Phone No.:

Gender: Relationship: Is this dependent currently employed? YES / NO

Current Employer: Hire Date: Phone No.:

Is this dependent currently covered through another medical plan? YES / NO Is this Family Coverage? YES / NO

If "YES", Name of Insurance: Policy ID:

Effective Date: Termination Date: Is this COBRA Coverage? YES / NO

*** * * IMPORTANT * * ***

If you and/or member of your family become covered by another insurance plan or terminate from your other insurance plan, please notify us in writing of any change, including Effective or Termination Date.

I certify that all the answers on this application are true to the best of my knowledge and belief. I further understand that any false statement may disqualify me for any benefits, and the Trustees of the Fund shall have the right to recover any payments made to me in reliance upon any false statement.

Member's Signature: Date:

Office Use Only

Coverage

Effective Date: _____

Termination Date: _____

Life Insurance: $_____

Employer ID No.: _____

Medical: Single / Family

Hospital: Single / Family

Rx Drug: Single / Family

Optical: Single / Family

Dental: Single / Family

[ ] New Enrollment
[ ] Re-instatement
[ ] Name Change
[ ] Address Change
[ ] Status Change
[ ] Benefit(s) Change
[ ] Adding Dependent(s)
[ ] Other:

ENROLLMENT FOR LIFE INSURANCE

PLEASE TYPE OR PRINT

EMPLOYER POLICYHOLDER'S NAME: **DISTRICT COUNCIL 37**
HEALTH & BENEFIT FUND

EMPLOYEE INSURED'S NAME:	*(Last)*	*(First)*	*(Middle Initial)*
STREET:			
CITY:	**STATE:**	**ZIP CODE:**	
Social Security #:	**Date of Birth:** *(Month)* *(Day)* *(Year)*		
Telephone #:	**Place of Birth:** *(City, State)*		
EMPLOYER:		**Hire Date:**	

Beneficiary Designation
(Please indicate a Primary and Contingent beneficiary)

PRIMARY
The proceeds shall be divided equally among those of the following designated person or persons who survive the insured.

1	Name	Relationship
	Address, City, State, Zip-Code	
2	Name	Relationship
	Address, City, State, Zip-Code	

CONTINGENT
The proceeds shall be divided equally among those of the following designated person or persons who survive the insured provided no primary beneficiary designated above has survived the insured.

1	Name	Relationship
	Address, City, State, Zip-Code	
2	Name	Relationship
	Address, City, State, Zip-Code	

I understand that this coverage shall become effective only if this application is accepted.

Signature _____ **Date** _____

RETURN TO:

District Council 37 Health & Benefit Fund
420 West 45th Street, 3rd Floor
New York, NY 10036

Revision Date : July 2022