ENROLLMENT FOR LIFE INSURANCE

PLEASE TYPE OR PRINT

EMPLOYER POLICYHOLDER'S NAME: **DISTRICT COUNCIL 1707**
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 1707 Health & Benefit Fund
420 West 45th Street, 3rd Floor
New York, NY 10036

Revision Date : December 2011