



SOLUTIONS FOR THE UNION WORKPLACE

ENROLLMENT AND BENEFICIARY FORM

PLEASE PRINT

Please submit this form to:
GROUP ELIGIBILITY DEPARTMENT
The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
Phone: (202) 962-8978 • Fax: (202) 682-6661
Toll-free: (888) 222-8573

INSTRUCTIONS: This form is to be utilized for enrollment and beneficiary purposes only. All correspondence and questions should be addressed to the Fund/Employer maintaining your eligibility information.

For all new additions and reinstatements, complete the entire form, and sign at the bottom.

For all other needs, complete the appropriate section, and sign at the bottom.

Please Check: New Enrollment Reinstatement Address Change Beneficiary Change

SECTION A - Policyholder Information

Name of group policyholder: Downstate IL Laborers' D.C. Policy number: G-3254

Effective date: 8-1-2007 Local/Bill ID: _____

SECTION B - Insurance Amount

Life amount: \$ 2,000.⁰⁰ AD&D amount: \$ 2,000.⁰⁰ AH amount: \$ _____ LTD amount: \$ _____

Billing classes: _____

Duplicate certificate request

SECTION C - Insured Information

Name of insured: _____ Male Female
Last First Middle Active Retiree

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Date of birth: _____

Occupation: _____ Weekly earnings: _____ Date started working: _____

SECTION D - Beneficiary

NOTE: If the beneficiary is being changed, the new beneficiary will replace all prior designations and will be effective as of the date this form is signed.

Beneficiary name	Relationship to Insured	Date of birth	% of share	SSN:
Primary:				
1.			%	
2.			%	
Contingent:				
1.			%	
2.			%	

INSURED SIGNATURE (Required): _____ Date: _____

WITNESS SIGNATURE (Required for new adds, reinstatements or beneficiary change): _____ Date: _____

PLEASE COMPLETE REVERSE SIDE