Benefit Enrollment Form (ASB) (W)

ASB Fund - Welfare Fund

PLUMBERS LOCAL UNION No.1
WELFARE FUND

50-02 5th Street, Long Island City, New York 11101
Tel. (718) 835-2700

(A) Member Information *Use a ballpoint pen to complete form*

(1) Social Security Number _____ (2) Last _____ (3) First _____ (4) Init. _____

(5) Street _____ (6) City _____ (7) State _____ (8) Zip _____

(9) Date of Birth _____ (10) Sex M ☐ F ☐ (11) Home Phone Number / Cell Number _____

(12) E-mail Address _____

(13) Retired ☐ (14) Active ☐ (15) Current or Last Employer _____ (16) Last date of Employment _____

(B) Dependent Information: See the Welfare Summary Plan Description for a definition of Eligible Dependent

Name of Spouse (1) First Init. (2) Last	(3) Date of Birth Month Date Year	(4) Date of Marriage Month Date Year	(5) Social Security Number

Name of Dependent (6) First Init. (7) Last	(8) Date of Birth Month Date Year	(9) Relationship to member	(10) Social Security Number
(11)			
(12)			
(13)			
(14)			
(15)			

(16) Does spouse have own health coverage? YES ☐ NO ☐ If "**Yes**" complete the following information.

NAME OF INSURANCE CARRIER	NAME OF EMPLOYER	POLICY NUMBER	EFFECTIVE DATE

(C) Primary Beneficiary for Death Benefits for the Additional Security Benefit Fund, Vacation and Holiday Fund, and Welfare Fund: I hereby designate the following person(s) as my Primary Beneficiary(ies) to receive benefits, if any, payable at my death. You may attach a second form if you wish to name more beneficiaries. (**Note: Beneficiary percentage may be split, but must total 100 percent)**.

Name(s) of Primary Beneficiary(ies) Last First Init.	Percentage (0% to 100%)	Date of Birth	Social Security Number	Relationship to member
(1) 1				
(1a) Address				
(2) 2				
(2a) Address				

(D)Contingent and Successor Beneficiary for Death Benefits for the Additional Security Benefit Fund, Vacation and Holiday Fund, and Welfare Fund: If all of the above Beneficiary(ies) do not survive, I hereby designate the following person(s) to be my Contingent and Successor Beneficiary(ies) to receive any benefits that become due as a result of my death or which remain payable after the death of (all) the above named beneficiary(ies). (**Note: Beneficiary percentage may be split, but must total 100 percent)**.

Name(s) of Contingent and Successor Beneficiary Last First Init.	Percentage (0% to 100%)	Date of Birth	Social Security Number	Relationship to member
(1) 1				
(1a) Address				
(2) 2				
(2a) Address				

(E) Authorization: You may amend or revoke your designation at any time by filing another form.

Members Signature: _____ **Date:** _____

I understand that I may change this Beneficiary/Dependent Designation at any time by filing a new Beneficiary Designation Form with the Fund Office.
NOTE: You must **sign and date the form** in order for your designation to be accepted by the Fund Office.

If no Beneficiary is designated or if all designated Beneficiaries die or are invalidated, payment of Death Benefits with respect to the Employee or Beneficiary receiving benefits will be made in the following order: (1) surviving spouse of the deceased Employee or Beneficiary; (2) children of the deceased Employee or Beneficiary; (3) parents of the deceased Employee or Beneficiary; (4) brothers and sisters of the deceased Employee or Beneficiary; (5) personal representative of the deceased Employee's estate or deceased Beneficiary's estate. If there is more than one individual in a category, the benefit will be divided equally among them unless the employee states otherwise in a beneficiary designation. If a Beneficiary determined according to the procedures in this paragraph dies before all the payments are made, the remaining payments will be made to the relatives or estate of the original beneficiary as stated above.

NOTE: PLEASE MAKE A COPY OF THE FORM FOR YOUR PERSONAL RECORDS. **PIB.WFBD.11.2014**