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Family Medical Care Plan

Phone (706) 841-7000
Toll Free (877) 937-9602
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ENROLLMENT FORM

COMPLETE AND RETURN TO ADDRESS SHOWN ABOVE

EMPLOYEE INFORMATION

Name of Employee:_____ **SSN:** _____

Mailing Address:_____ **Phone Number:** _____

City:_____ **State:**_____ **Zip:** _____ **Local Union:**_____

Date of Birth: _____ **Sex:** ○ M ○ F **Marital Status:** ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed

Email:_____ **Current Employer:** _____

Coverage Election: ○ Employee Only ○ Employee+ Spouse ○ Employee + Children ○ Family

SPOUSE INFORMATION

Name of Spouse:_____ **SSN:** _____

Date of Birth: _____ **Sex:** ○ M ○ F **Marriage Date:** _____ **ATTACH A COPY OF MARRIAGE CERTIFICATE.**

CHILD INFORMATION

List all dependent children under age 26 if you have chosen Employee + Children or Family Coverage.

Full Legal Name	Relationship to You (natural child, stepchild, etc.)	Child's SSN	Date of Birth	Sex
1.				
2.				
3.				
4.				

FOR ANY NEWLY ENROLLED CHILD LISTED ABOVE, PLEASE SUBMIT A COPY OF THEIR BIRTH CERTIFICATE(S) OR COPIES OF ALL PERTINENT COURT ORDERS (DIVORCE DECREES, CUSTODY AWARDS, PATERNITY ORDERS, ETC.).

OTHER INSURANCE

Name of any family member through which other group coverage is provided:_____

Name, address, telephone no., and group/member I.D.s for that health plan:_____

_____

_____

LIFE INSURANCE BENEFICIARY

Designate one or more beneficiaries for your Life Insurance and AD&D Insurance benefits.

Primary Beneficiary(ies):

Full Legal Name	Relationship to You	SSN	Date of Birth	% of Total (must be equal to 100%)

Contingent Beneficiary(ies) – Insurance benefits will only be paid to a contingent beneficiary if there is no surviving primary beneficiary:

Full Legal Name	Relationship to You	SSN	Date of Birth	% of Total (must be equal to 100%)

The above-named beneficiary supersedes any and all beneficiaries previously designated. Designation of a beneficiary on this form will be valid only if the Fund Office receives this form while you (the employee) are still living.

Date Signed _____

Employee Signature _____