NECA/IBEW FAMILY MEDICAL CARE PLAN
410 Chickamauga Avenue, Suite 301
Rossville, GA 30741
http://www.NIFMCP.com

Phone (706) 841-7000 Fax (706) 841-7020 Toll Free (877) 937-9602

ENROLLMENT FORM

COMPLETE AND RETURN TO YOUR EMPLOYER

Name of Employee _____ Soc. Sec. No. _____

Address _____
(street number and street name)

_____ Telephone No. (____) _____
(city, state, zip code)

Local Union No. _____ Current Employer _____
(name, city, state, zip code)

Coverage Election: (circle one) **Employee Only** **Employee+Spouse** **Employee+Children** **Family**

Date of Birth _____ Sex: M F (circle one) Marital Status: Single Married/Date_____ Div Sep Legally Sep Widowed (circle one)

Name of Spouse _____ Date of Birth _____ Soc. Sec. No _____

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 _____

_____

List all dependent children under age 26 (If you have chosen Employee+Children or Family Coverage)

Full Legal Name	Relationship to you (natural child, step-child, etc.)	Does child live with you?	Child's Social Security Number	Date of Birth	Sex
1.					
2.					
3.					
4.					
5.					
6.					

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

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	Social Security Number	Date of Birth	% of total (must equal 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	Social Security Number	Date of Birth	% of total (must equal 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**