NECA/IBEW FAMILY MEDICAL CARE PLAN
410 Chickamauga Avenue, Suite 301
Rossville, GA 30741
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Phone (706) 841-7000 Fax (706) 841-7020 Toll Free (877) 937-9602

FAMILY ENROLLMENT FORM MEDICARE RETIREE

COMPLETE AND RETURN TO ADDRESS SHOWN ABOVE

Name of Employee ______________________________ Soc. Sec. No. ______________

Address and PO Box ______________________________ Medicare #______________
(Must have both the street number, street name and PO Box number)

______________________________ Telephone No. (______) ______________
(city, state, zip code)

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

Job Class: Journeyman (or above) Apprentice Construction Elec. Construction Wireman Non-Bargained-for Other: ______________
(circle one)

Date of Birth ______________ Sex: M F Marital Status: Single Married Div Sep Legally Sep. Widowed
(circle one) (circle one)

Name of Spouse ______________ Sex: M F Date of Birth __________ Soc. Sec. No ____________ Medicare #______________
(circle one)

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 ______________________________

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List all dependent children under age 26

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 CERTIFIED BIRTH CERTIFICATE AND COPIES OF ALL PERTINENT COURT ORDERS (DIVORCE DECREES, CUSTODY AWARDS, PATERNITY ORDERS, ETC.).

LIFE INSURANCE COVERAGE IS FOR THE MEMBER ONLY

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**