Enrollment and Beneficiary Form

PLEASE PRINT.

The Union Labor Life Insurance Company

Policyholder Information

A

Effective Date	New Addition ☐ Reinstatement ☐ *Complete Entire Card	Insurance Change ☐ *Complete Section B	General Change ☐ *Complete Section C	Address Change ☐ *Complete Section G
Name of Group Policyholder			Policy Number	Local/Bill ID

B

Life Amount $	AD&D Amount $	AH Amount $	LTD Amount $	
List Billing Classes:				Duplicate Certificate Request ☐

Insured Information

C

Insured SS#	Insured Name: Last	First	Middle			
Date of Birth / /	Male ☐ Female ☐	Status Active ☐ Retiree ☐	Date Started Working / /	Weekly Earnings $	Occupation	
Beneficiary Change ☐ *Complete Section D	Beneficiary Designation					

D

If the beneficiary is being changed, the new beneficiary will replace all prior designations and will be effective as of the date signed	Beneficiary Relationship	Beneficiary SS#

E

Insured Signature (Required) Date / /	Witness Signature (Required for new adds, reinstatements or beneficiary change)	Date / /

Dependent Information

Complete only if dependent benefits are included in the insurance program. List all dependents eligible for Coverage

F

TRANS
"A" for dependent
"T" for termination of dependent
"M" for change of dependent information

STATUS
"C" for child
"S" for student
"D" for disabled adult

	First Name	Last Name	Dependent SS#	Relationship	Sex	M/F	Date of Birth: Month	Day	Year

G

Insured Address Street		
City	State	Zip Code

The above sheet 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 your protection, the following states require these fraud warnings to appear on this form:

Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.

I attest that I have reviewed, understand and acknowledge the fraud warning(s).

_____ _____

Member or Claimant's Signature Date