SOUTHEASTERN IRON WORKERS
HEALTH CARE PLAN

Administered by Southern Benefit Administrators, Incorporated

Mailing Address:
P. O. Box 1449
Goodlettsville, TN 37070-1449

Telephone: (615) 859-0131
Toll Free: (800) 831-4914
Fax: (615) 859-6792

Street Address:
2001 Caldwell Drive
Goodlettsville, TN 37072-2328

ENROLLMENT FORM

Please complete this form in its entirety, front and back and return it in the enclosed envelope. The information requested below is very important as it provides the Plan office with current information about you and your dependents. Please only list those dependents who meet the definition of an Eligible Dependent, as that term is defined in your Summary Plan Description. This form also allows you to designate a beneficiary for the purpose of receiving benefits from the Fund upon your death. Please sign and date the form.

In order to enroll dependents below for coverage under the Plan, please provide copies of marriage certificate(s) and birth certificate(s) (For Children only). The Plan office will not verify dependent coverage to providers or process claims on their behalf without this documentation. If you have previously provided this information for each of the dependents you list below, it is not necessary for you to submit it again.

INFORMATION REGARDING YOU AND YOUR DEPENDENTS

Participant Name:_____ Date of Birth: _____Sex:_____

Address:_____City:_____State: _____

Zip Code:_____ Social Security No:_____ Local Union No._____

Participant's Email Address:_____Phone Number:_____

Spouse's Name:_____Date of Birth: _____Sex:____

Spouse's Social Security No.:_____ Date of Marriage:_____

Spouse's Email Address: _____Phone Number:_____

Dependent Children:

Names:	Birthdate:	Social Security #	Relationship	Sex:

DESIGNATION OF BENEFICIARY

Beneficiary Name:_____ Social Security #:_____

Address (if different):_____

Contingent Beneficiary Name(s):_____ Social Security#: _____

_____ _____

IF YOU OR A DEPENDENT HAVE OTHER HEALTH COVERAGE, COMPLETE THIS SECTION

Name of Covered Individual:_____

Group No:_____ Contract No.:_____

Name/Address of Insurance Company or Plan:_____

Telephone number of Insurance Company or Plan:_____

Effective date of coverage_____ Termination date of coverage (if applicable)_____

Type of coverage:_____Single _____ Family

_____ Medical _____ Dental _____ RX _____ Vision

Is your other coverage PPO or HMO? _____

IF YOU OR A DEPENDENT HAVE MEDICARE COVERAGE, COMPLETE THIS SECTION

Name of Covered Individual:_____

Medicare Health Insurance (HIC) Number:_____

Enrolled in:_____ Part A _____ Part B _____ Part D

Medicare Eligibility based on: _____ Age _____ Disability _____ End Stage Renal Disease

Signature:_____ **Date:**_____

THIS FORM MUST BE SIGNED AND DATED BY THE PARTICIPANT