PLUMBERS AND FITTERS LOCAL NO 110
BENEFIT TRUST FUND
Administered by Southern Benefit Administrators, Inc.

Mailing Address:
5305 Virginia Beach Boulevard
Norfolk, VA 23502

Telephone: (757) 461-8091
Fax: (757) 461-2920

ENROLLMENT FORM

Please complete this form fully front and back and return it in the enclosed envelope. The information requested below is very important as it provides the Fund office with current information about you and your dependents. This form also allows you to designate a beneficiary for the purpose of receiving benefits from the Fund upon your death. **You must sign and date the form.**

The "Patient Protection and Affordable Care Act", a health care reform bill enacted by Congress and signed into law by the President in March 2010, provides that group health plans that cover dependent children must extend coverage for such dependents until attainment of age 26. In addition, a dependent child may **not** be excluded based on the following criteria: financial dependency, residency, student status, marital status or employment. Also, if you designate any step-children, additional information may be requested.

INFORMATION REGARDING YOU AND YOUR DEPENDENTS

Employee Name: _____ Birthdate: _____

Address: _____ City: _____State:___ Zip Code: _____

Phone #: _____ Social Security No: _____

Email: _____

Spouse's Name: _____ Spouse's Birthdate: _____

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

Other Dependents:

Name	Birthdate	Social Security Number	Relationship	Sex

Signature: _____ **Date:** _____

YOU MUST SIGN AND DATE THIS FORM

DESIGNATION OF YOUR BENEFICIARY

Beneficiary Name: _____ Relationship: _____

Social Security No:_____

Address (if different): _____

_____

Contingent Beneficiary: _____ Relationship: _____

Signature: _____ Date: _____

COMPLETE IF YOU OR ANY OF YOUR FAMILY MEMBERS PRESENTLY HAVE OR HAVE HAD OTHER COVERAGE WITHIN THE PAST TWELVE (12) MONTHS

Name of Covered Individual: _____

Date of Birth: _____ Relationship to Employee: _____

Covered Individual's Employer: _____

Social Security No: _____ Group No: _____ Contract No: _____

Name/Address of Insurance Company or Plan: _____

Is this coverage presently in force? _____Yes _____ No

If yes, when did it become effective?_____

If not, what was the date of termination? _____
(Please attach a Certificate of Creditable Coverage regarding your previous coverage, if available)

Type of Coverage: ☐ Single ☐ Family

Check All That Apply: _____ Medical Coverage
☐ Dental Coverage
☐ Drug Card
☐ Vision Coverage

If you or a Dependent Have Medicare Coverage, Complete the Following:

Covered Individual(s) Name: _____

Medicare Health Insurance Claim (HIC) Number: _____

Enrolled for: ☐ Part A ☐ Part B ☐ Part D

Medicare Eligibility Based On:

☐ Age ☐ Disability ☐ End Stage Renal Disease