NATIONAL IAM
BENEFIT TRUST FUND
*Better Benefits · Better Life*

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# ENROLLMENT FORM

☐ **NEW EMPLOYEE** **EFFECTIVE DATE:** / /

☐ **INFORMATION UPDATE** **HIRE DATE:** / /

☐ **DEPENDENT ENROLLMENT** **RETIREMENT DATE:** / /

## EMPLOYEE INFORMATION – Please print clearly

**Name:** _____ **SSN:** - -
(Last) (First) (Middle)

**Address:** _____ **Date of Birth:** / /
(Street) (City, State, Zip)

**Gender:** ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

**Home Phone:** _____ **Cell Phone:** _____ **Work Phone:** _____

**Email:** _____ **Employer Name:** _____

**Are you covered by a Collective Bargaining Agreement?** ☐ Yes ☐ No **Actively working?** ☐ Yes ☐ No

**Do you want to cover eligible dependents, a spouse, or a domestic partner?** ☐ Yes ☐ No **If yes, please list:**

## DEPENDENT INFORMATION – Please print clearly

***PLEASE NOTE***: Coverage of any dependent is subject to Plan provisions, including the submission of certain forms or legal documents. If you list dependent children who are not your biological children, or do not have your last name, you must complete an ***Eligible Dependent Certification Form*** for such dependents. If you are covering a spouse, you must provide your ***Marriage Certificate***. If you are covering a domestic partner, you must include an ***Affidavit of Domestic Partnership***. Contact the Plan if you have any question about what to submit when you enroll your dependents. You will be notified if any other documents or forms are required when your enrollment form is reviewed.

| Last Name | First Name | M.I. | Relationship | Gender M | Gender F | Date of Birth | SSN |
|---|---|---|---|---|---|---|---|
| | | | | ☐ | ☐ | / / | - - |
| | | | | ☐ | ☐ | / / | - - |
| | | | | ☐ | ☐ | / / | - - |
| | | | | ☐ | ☐ | / / | - - |
| | | | | ☐ | ☐ | / / | - - |

## BENEFICIARY INFORMATION FOR LIFE AND AD&D COVERAGE – Please print clearly

***COMPLETE ONLY IF YOUR EMPLOYER PROVIDES LIFE AND AD&D COVERAGE.*** Please print the FULL NAME(S) of your beneficiaries. For additional beneficiaries, please continue this list on the reverse, or attach a second sheet. NOTE: If more than one Primary (or secondary) beneficiary is listed, benefits will be split evenly. Secondary beneficiaries will only receive a benefit if all Primary beneficiaries are deceased.

| | Last Name | First Name | Middle Name | Relationship | Primary / Secondary |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |

## EMPLOYEE CERTIFICATION AND SIGNATURE

I hereby make application to join the National IAM Benefit Trust Fund, and request the benefits to which I am entitled, or to which I may become entitled under the provisions of the Plan. I authorize the proper deductions, if any, from my earnings as my contribution toward the cost of benefits. **I declare under penalty of law that all of the foregoing information is correct**.

**Employee Signature:** _____ **Date Signed:** / /

**IMPORTANT:** Future changes in employee, dependent, domestic partner, or beneficiary information (including change of address) should be reported by completing and returning a new Enrollment Form that will **replace** the prior form. Enrollment, Dependent Certification, and Domestic Partnership Affidavit forms can be found on our website at www.iambtf.org, or you can contact your employer or the Fund Office for assistance.