DC 37 HEALTH AND SECURITY PLAN
55 Water Street
New York, NY 10041
Telephone: (212) 815 - 1234
Fax: (212) 298 - 9880

ENROLLMENT FORM

(PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING THIS FORM)
(PRINT OR TYPE IN BLACK INK AND IN CAPITAL LETTERS)

SECTION A: MEMBER'S INFORMATION

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	MI
___ — ___ — ____			

DATE OF BIRTH (MONTH / DAY / YEAR)	GENDER	DATE OF HIRE (MONTH / DAY / YEAR)	DEPT./AGENCY
/ /	☐ MALE ☐ FEMALE	/ /	

HOME STREET ADDRESS	APT. NO.	HOME PHONE
		( ) -

CITY	STATE	ZIP CODE	CELL PHONE
			( ) -

CURRENT STATUS: Please check one box.

NOTE: A date is required if an option other than single is selected

☐ MARRIED — MONTH DAY YEAR ___/___/___
☐ SEPARATED — MONTH DAY YEAR ___/___/___
☐ DIVORCED — MONTH DAY YEAR ___/___/___
☐ WIDOWED — MONTH DAY YEAR ___/___/___
☐ DOMESTIC PARTNER — MONTH DAY YEAR ___/___/___
☐ SINGLE

EDUCATION LEVEL: (Circle One)
College:
1yr 2yr 3yr BA BS Other _____

High School Diploma or Equiv:
☐ Yes ☐ No

If no High School Diploma, (Circle One)
Highest Year Completed:
4 5 6 7 8 9 10 11

WORK PHONE
( ) -

Home E-Mail Address (Optional)
_____

If you enroll any dependents, spouse or domestic partner, it is mandatory that you attach all required documents (i.e. **BIRTH CERTIFICATE, MARRIAGE CERTIFICATE, ADOPTION DOCUMENTS** or **REGISTRATION OF DOMESTIC PARTNERS**) before any benefits will be provided to dependents, spouse or domestic partner.

SECTION B: SPOUSE OR DOMESTIC PARTNER INFORMATION

SS# OF SPOUSE/DOMESTIC PARTNER	LAST NAME (If Different)	FIRST NAME	MI
___ — ___ — ____			

DATE OF BIRTH (MONTH / DAY / YEAR)	GENDER	NAME OF EMPLOYER	DATE OF HIRE (MONTH / DAY / YEAR)
/ /	☐ MALE ☐ FEMALE		/ /

WORK ADDRESS	ZIP CODE	WORK PHONE
		( ) -

NAME OF SPOUSE/DOMESTIC PARTNER'S UNION/LOCAL # IF APPLICABLE	PHONE No. of SPOUSE/DOMESTIC PARTNER'S UNION/LOCAL
	( ) -

ADDRESS/ZIP CODE OF SPOUSE/DOMESTIC PARTNER'S UNION/LOCAL # IF APPLICABLE

Benefit	Name of Insurer	Address/Zip Code of Insurer	Phone # of Insurer	Policy #	Coverage Individual or Family
Drug					
Dental					
Health Insurance					

COMPLETE OTHER SIDE :

SECTION C: DEPENDENT INFORMATION (NOTE - If there are additional dependents, please list on a separate page.)

DEPENDENT SS#	FIRST NAME	LAST NAME (IF DIFFERENT)	DATE OF BIRTH	GENDER
___ — ___ — ___			MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE
RELATIONSHIP ☐ SON ☐ DAUGHTER ☐ STEP-SON ☐ STEP-DAUGHTER OTHER:_________				
DEPENDENT SS#	FIRST NAME	LAST NAME (IF DIFFERENT)	DATE OF BIRTH	GENDER
___ — ___ — ___			MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE
RELATIONSHIP ☐ SON ☐ DAUGHTER ☐ STEP-SON ☐ STEP-DAUGHTER OTHER:_________				
DEPENDENT SS#	FIRST NAME	LAST NAME (IF DIFFERENT)	DATE OF BIRTH	GENDER
___ — ___ — ___			MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE
RELATIONSHIP ☐ SON ☐ DAUGHTER ☐ STEP-SON ☐ STEP-DAUGHTER OTHER:_________				
DEPENDENT SS#	FIRST NAME	LAST NAME (IF DIFFERENT)	DATE OF BIRTH	GENDER
___ — ___ — ___			MONTH DAY YEAR ___/___/___	☐ MALE ☐ FEMALE
RELATIONSHIP ☐ SON ☐ DAUGHTER ☐ STEP-SON ☐ STEP-DAUGHTER OTHER:_________				

SECTION D: DEATH BENEFITS TO BE PAID TO

1) BENEFICIARY(IES): If more than one primary beneficiary is named, the Death Benefit will be divided equally among them, unless otherwise indicated.

LAST NAME OF BENEFICIARY		FIRST NAME			MI
BENEFICIARY ADDRESS		APT. #	CITY		
STATE	ZIP CODE	TELEPHONE NUMBER	RELATIONSHIP	DATE OF BIRTH (MONTH / DAY / YEAR)	
LAST NAME OF BENEFICIARY		FIRST NAME			MI
BENEFICIARY ADDRESS		APT. #	CITY		
STATE	ZIP CODE	TELEPHONE NUMBER	RELATIONSHIP	DATE OF BIRTH (MONTH / DAY / YEAR)	

2) CONTINGENT BENEFICIARY(IES) In the event the primary beneficiary(ies) predecease(s) the insured, I designate as contingent beneficiary(ies).

LAST NAME OF BENEFICIARY		FIRST NAME			MI
BENEFICIARY ADDRESS		APT. #	CITY		
STATE	ZIP CODE	TELEPHONE NUMBER	RELATIONSHIP	DATE OF BIRTH (MONTH / DAY / YEAR)	
LAST NAME OF BENEFICIARY		FIRST NAME			MI
BENEFICIARY ADDRESS		APT. #	CITY		
STATE	ZIP CODE	TELEPHONE NUMBER	RELATIONSHIP	DATE OF BIRTH (MONTH / DAY / YEAR)	

NOTE: If there are additional beneficiaries, please list on a separate page.

ATTENTION : I attest that the information entered on this form is true and accurate and I understand that I and my family may lose benefit coverage if any of the information given on this form is false.

X ______________________________
MEMBER/EMPLOYEE SIGNATURE

____
DATE

Health & DC37 Security Plan

Instructions on How to Complete The Attached Enrollment Form

In order for the DC 37 Health and Security Plan to provide Welfare Fund Benefits to you and your dependents you must complete the attached Enrollment Form.

PLEASE NOTE THE FOLLOWING:

- As a new employee, enrolling a spouse, domestic partner or dependent child (ren) in the Plan for the first time, you must attach the appropriate documentations (your marriage certificate, domestic partnership papers and birth certificate(s) of your child (ren) to your Enrollment Form.
- If you were previously enrolled and want to add or change your spouse, domestic partner or dependent information, please submit a "Change of Status Form".
- Sign and date the Enrollment Form.
- Please send the Enrollment Form to the following address:

DC 37 Health and Security Plan
55 Water Street
New York, NY 10041
Tel: (212) 815-1234
Fax: (212) 298-9880
Email: eeu@dc37.net

If you have any questions, feel free to contact our Plan office at 212-815-1234.