ENROLLMENT FORM

DESIGNATION OF BENEFICIARY & DEPENDENT INFORMATION

PLEASE PRINT – MUST BE FILLED IN WITH INK

1. MEMBER's FULL NAME _____
(LAST NAME) (FIRST NAME)

2. LOCAL: ☐ Loc 7 ☐ MARBLE ☐ OTHER _____

3. ADDRESS _____
NO. STREET CITY OR BOROUGH ZIP STATE

4. HOME PHONE _____ 5. WORK PHONE _____ 6. CELL PHONE _____

7. E-MAIL _____ 8. BIRTHDATE ___/___/_____ 9. SOC. SEC. NO. _____--_____--_____

10. CHECK ONE: ☐ SINGLE ☐ MARRIED (WEDDING DATE _____) ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED

11. EMPLOYER NAME _____ START _____ TERMINATED _____

12. ADDRESS _____
NO. STREET CITY OR BOROUGH ZIP STATE

You may name one or more beneficiaries. Use full name such as Ann Smith not Mrs. John Smith. (If more space is needed, continued on the other side)

NAME OF PRIMARY BENEFICIARY _____ RELATIONSHIP _____

ADDRESS _____

NAME OF CONTINGENT BENEFICIARY _____ RELATIONSHIP _____

ADDRESS _____

If more than one beneficiary is named, the death benefits, unless otherwise provided herein, will be paid in the above order to the designated beneficiaries who survive the employee: If no beneficiary survives, payment will be made in accordance with the rules adopted by the Trustees.

I understand that by my participation in the program for Local 7; Local 7 Pension Trust Fund, Marble; Marble Pension Trust Fund, any death benefit payable under such program or programs shall be payable to the beneficiary above names by me. I further understand that the beneficiary or beneficiaries may be changed by me at any time.

IF YOU HAVE NO DEPENDANTS WRITE NONE

BENEFICIARY INFORMATION	CHECK RELATIONSHIP				DATE OF BIRTH		
FULL NAME	SPOUSE	DEPENDENT	M	F	MONTH	DAY	YEAR

DEPENDENT INFORMATION

LIST BELOW NAMES OF SPOUSE & UNMARRIED DEP. CHILDREN	CHECK RELATIONSHIP				DATE OF BIRTH		
FULL NAME	SPOUSE	DEPENDENT	M	F	MONTH	DAY	YEAR

DATE _____ SIGNATURE _____
(DO NOT PRINT)

Complete and mail to:
Attn: Enrollment Department
Daniel H. Cook Associates
253 West 35th Street- 12th Floor
New York, NY 10001

* New Members!!! Please include copies of the following:

- ☐ Social Security Cards
- ☐ Birth Certificates
- ☐ Marriage Certificate or QDRO/Divorce Documents
- ☐ Death Certificates
- ☐ Notarized Affidavit of Spousal Coverage
- ☐ PAID bursar's bill specifying semester/terms for ALL dependents ages 19-22
- ☐ English translation for all foreign documents submitted

Tile Layers Union Local 7 Welfare Fund
Supplemental Benefits
253 West 35th Street, 12th Floor
New York, N.Y. 10001
(212) 505 – 5050

APPLICATION FOR SUPPLEMENTAL

Unemployment Insurance, Workers Compensation, Disability, and Jury Duty Benefits

Eligibility: Member MUST have an initial account balance of $2,000, and MUST maintain an ongoing balance of at least $1,000, in the Tile Helpers Local 88 Welfare Fund Supplemental Benefit Plan.

Name: _____

Address: _____
(Street No.) (Street Name) (City) (State) (Zip)

Telephone Number: (_____) _____-_____ **Social Security No:** _____-_____-____

Local Union No. _____ **Last Employer:** _____

Last Date Employed _____ **Claim Period From** _____ **to** _____

I agree that Supplemental Unemployment Insurance Benefits, Workers Compensation Benefit, Disability Benefit, and Jury Duty Benefit are to be governed in all respects by the provisions of the Supplemental Plan, or as the same may hereafter be amended; and that the payment of any Supplemental Benefit and its acceptance by me shall not prevent the Board of Trustees from recovering or otherwise affect their rights to recover any payment to me in excess of the amount to which I am entitled under the provisions of the Program, no shall the payment of any Supplemental Insurance Benefits to me obligate the Board of Trustees in any way to make any further payments in any amount whatsoever, except as the same may be provided for by the Plan or as it may from time to time be amended.

All payments made under this Plan will be reported to the Internal Revenue Service. It is necessary that payments received by you are reported in your income tax return, (The Fund Office will send you a Form W2 submitted to I.R.S.). All distributions will be taxed by the Federal, State and Local in addition FICA tax will be deducted both the employee and Employer portions.

Date: _____/_____/_____ **Signature:** _____

This application must be accompanied by proof of payment from a State Unemployment insurance Department, Compensation payments, Disability award papers and or Jury Duty payment voucher.