

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department (HR Dept.).

APPLICANT	Your Name (Last, First, Middle)		Group Name Teamsters Local Union, No. 118		Group Number(s) 645321	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation	
LIFE	For questions about the coverage options available to you, and any Evidence Of Insurability requirements, ask your HR Dept. Life Insurance <input checked="" type="checkbox"/> Life with AD&D Employer Paid					
BENEFICIARY	This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.					
	Primary - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
	Contingent - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
CHANGE	Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.					
<input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name Change <input type="checkbox"/> Beneficiary Change Date of add/delete _____ Former name _____ <input type="checkbox"/> Other _____						
SIGNATURE	I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. Fraud Notice - Only applies to Accident and Health Insurance (AD&D/Disability/Dental): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance of statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____					
HR Dept. - Complete this section. Retain form for your records.						
Dvsn ID	Billing Cat	Date of Hire/Rehire	Hrs. Worked Per Wk	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr	