DOBBS FERRY WELFARE FUND ENROLLMENT AND DEPENDENT INFORMATION

1. Member's Full Name: _____ _____
   (LAST NAME) (FIRST NAME)
2. Address: _____
   (STREET # AND NAME)

   _____ _____ _____
   (CITY) (STATE) (ZIP CODE)
3. Home Phone: _____ Cell Phone: _____
4. Work Phone: _____
5. Email: _____
6. Birthday: ____/_____/_____ SSN: _____-_____-_____ NYSUT #(if applicable) _____
7. Check One: Single _____ Married _____ Widowed _____ Divorced _____ Legally Separated _____
8. School Name: _____
9. Hired Date: _____ Retired Date: _____

Dependent Information

Dependents over 19 years of age, must be full time students - Paid bursar's bill specifying semester/terms for ALL dependents ages 19-23 must be submitted every semester

	Name	Date of Birth	Sex M/F	SSN
Spouse				
Dependent #1				
Dependent #2				
Dependent #3				
Dependent #4				
Dependent #5				
Dependent #6				

10. Spouse's Employer _____
11. Address of Employer _____
12. Are you or your spouse covered by any other Dental Plan? _____
13. Is the other plan a group or individual plan? _____
14. Who is the policy holder? _____

Under penalty of perjury, including, but not limited to, prosecution for insurance fraud and a permanent termination of benefits from this fund, I attest that the above is true and accurate to the best of my knowledge. I also promise to notify the Fund at 212-505-5050 if any of the aforementioned information should change.

Date _____ Signature _____
(DO NOT PRINT)

BENEFICIARY DESIGNATION FORM
GROUP LIFE AND GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
First Unum Life Insurance Company
Provident Life and Casualty Insurance Company
The Paul Revere Life Insurance Company

Instructions: Please complete, sign and date this form to designate your beneficiary(ies) or to change your existing beneficiary(ies). This form cancels all prior designations. If more than one beneficiary is named and no percentages are indicated, payment will be made to them in equal shares. If there are more than three (3) primary and/or contingent beneficiaries, please attach a separate sheet of paper. **Return the completed form to your employer.**

SECTION 1: Employee Information

Name (Last Name, Suffix, First Name, MI)	Social Security Number

Employer Name	Check the coverages listed below to which this beneficiary designation applies: ☐ Basic Life ☐ Supplemental Life ☐ AD&D ☐ All

SECTION 2: Primary Beneficiary (ies)

I choose the person(s) named below to be the primary beneficiary(ies) of the Life Insurance benefits that may be payable at the time of my death. If any primary beneficiary(ies) is disqualified or dies before me, his/her percentage of this benefit will be paid to the remaining primary beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 3: Contingent Beneficiary (ies)

If **all** primary beneficiaries are disqualified or die before me, I choose the person(s) named below to be my contingent beneficiary(ies).

Name & Address	Relationship	Social Security Number	Date of Birth	Percentage
				Total Must Equal 100%

SECTION 4: Signature

X _____ _____

Employee Signature **Date**

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