NATIONAL IAM
BENEFIT TRUST FUND

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Website: www.iambtf.org

ENROLLMENT FORM

☐ NEW EMPLOYEE	FULL-TIME EMPLOYEE ☐	HIRE DATE:	/ /
☐ INFORMATION UPDATE	PART-TIME EMPLOYEE ☐	EFFECTIVE DATE:	/ /
☐ DEPENDENT ENROLLMENT	RETIREE ☐	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 your eligible dependent children or spouse? ☐ Yes ☐ No **If yes, please list below.**

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***. 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		Date of Birth	SSN
				M	F		
				☐	☐	/ /	- -
				☐	☐	/ /	- -
				☐	☐	/ /	- -
				☐	☐	/ /	- -
				☐	☐	/ /	- -

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

COMPLETE ONLY IF YOUR EMPLOYER PROVIDES LIFE AND AD&D COVERAGE THROUGH THIS FUND. Print the FULL NAME(S) of your beneficiaries. If necessary, please continue 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, 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 and Dependent Certification forms can be found on our website at www.iambtf.org, or you can contact your employer or the Fund Office for assistance.