**ASBESTOS WORKERS LOCAL NO. 33 HEALTH FUND**
**MEMBER CENSUS - INFORMATION FORM**

Member Last Name | First | Middle | Date of Birth

Social Security Number | Present Local Union # | Home Phone

Home Address – Street | ☐ Male/☐ Female

City | State | Zip Code

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Legally Separated ☐ Separated ☐ Widowed

Spouse's Last Name | First | Middle | Date of Birth

Spouse's Employer Name | Social Security Number

Employer's Address – Street | Employer Phone Number

City | State | Zip Code

Name of Group Health Insurance Plan of Spouse's Employer

Type of Insurance ☐ Medical ☐ Dental | Policy/Group Number | Phone Number Insurance Carrier

| Dependent Child(ren) First Name MI Last Name (if different) | Sex | Date of Birth M / D / Y | Social Security Number |
|---|---|---|---|
| | ☐ Male ☐ Female | / / | |
| | ☐ Male ☐ Female | / / | |
| | ☐ Male ☐ Female | / / | |
| | ☐ Male ☐ Female | / / | |
| | ☐ Male ☐ Female | / / | |

Are any Child(ren) handicapped ☐ Yes ☐ No. If yes, please provide separate note with description.

Are any of your Dependent Child (ren) attending Accredited School/College? ☐ Yes ☐ No If yes, complete the following. You will be required to furnish student letter each semester.

# 1 Child's Name | School/University Name

Year at School ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate | Number of Credits

# 2 Child's Name | School/University Name

Year at School ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate | Number of Credits

**DESIGNATION OF BENEFICIARY**

This form designates your beneficiary for any life insurance and/or accidental death and dismemberment (AD&D) benefit.

I hereby designate as my beneficiary to receive any life insurance and AD&D benefits payable at my death by Health Fund:

Beneficiary's Name ______________________________

Social Security Number ____________________ Relationship ____________________

Street Address ______________________________

City ____________________ State ____________________ Zip Code ____________

This Beneficiary designation revokes all previous designations of beneficiary for the Health Fund.

Member Signature ______________________________ Date ____________________

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