Pressmen Welfare Fund

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (888) 834-6966
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
Telephone: (888) 834-6966
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HEALTH & WELFARE ENROLLMENT FORM

MAIL COMPLETED FORM TO:
Pressmen Welfare Fund
8400 Corporate Drive, Suite 430, Landover, MD 20785-2361

Last Name	First Name	MI	**OFFICE USE ONLY** Effective	Terminated
Address			A.	
			B.	
City	State	Zip Code	C.	
Telephone:	Date Employed		D.O.B	
Email:				
Your Social Security Number	Name of Employer			
Marital Status: Married Single Widowed Divorced Separated Date of Marriage:				
If Retired, Date of Retirement	Type of Retirement (Normal, Disability, Etc.)		Medicare Eligible? Yes No	
Name of any other health insurance covering you Policy No.: Name of Insurance: Employer:				
Source of other coverage is: Another Job Spouse's Plan Other:				
If other coverage was declined on you or any dependent, did you receive cash or benefit dollars for declining? Yes No If yes, please attach explanation.				
Choose Your Dental Coverage: Cigna Dental HMO Plan (or) Dental Indemnity Plan (or) Opt Out				
Life Insurance to be paid to (Name/Relationship)	Beneficiary's Address			
Date Signed: Signature:				

PLEASE READ BOTH SIDES OF FORM CAREFULLY

I hereby apply for participation in the Pressmen Welfare Fund. I understand that this application is subject to my being employed by a Participating Employer and covered by a collective bargaining agreement with Pressman Local 72. I agree to follow the rules and regulations as determined by the Board of Trustees as communicated to me in my Summary Plan Description or updates thereto.

I certify that I have carefully read both sides of this enrollment form and agree to the terms specified thereon. The foregoing statements are complete, true, and correctly recorded.

Date _____ Signature (Do Not Print) _____

LIST BELOW NAMES OF YOUR SPOUSE AND CHILDREN UNDER 26 YEARS OF AGE.

LIST NAMES IN ORDER OF AGE – ELDEST FIRST	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

Address of Dependent If Different From Member: _____

_____

A COPY OF YOUR MARRIAGE LICENSE AND/OR DEPENDENT'S BIRTH CERTIFICATE MUST BE INCLUDED WITH THIS APPLICATION.

Name any other health insurance covering your dependent(s), including Medicare:

Name of Insured: _____ Type of Insurance: _____ Policy No.:_____

Name of Insured: _____ Type of Insurance: _____ Policy No.:_____

SPECIAL ENROLLMENT PROVISIONS

If you turned down coverage for either yourself or for your dependents because you were covered under another group plan, and then that other coverage ends, you may be able to enroll yourself and your dependents under the Fund, **provided you do so within 30 days from the date your other coverage ended**. However, there are only a limited number of circumstances when you can enroll when you lose coverage. If the other coverage was COBRA coverage, you may request enrollment under this Fund only if the COBRA coverage is exhausted. For other group coverage, you may request enrollment under this Fund if the other coverage was lost as a result of loss of eligibility or because employer contributions toward the other coverage ceased.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days from the date of marriage, birth, adoption or placement for adoption. To request enrollment information, contact the Fund Office at (888) 834-6966 and ask for the Eligibility Department.