Truck Drivers and Helpers Local 355
Baltimore Area Health & Welfare and Pension Funds
Eastern Shore Teamsters Pension Fund

9411 Philadelphia Road, Suite S - Baltimore, Maryland 21237
Telephone Numbers: (443) 573-3632 (866) 621-7974 Fax (410) 444-0035

The purpose of this form is to designate beneficiaries for the: 1) Truck Drivers and Helpers Local Union No. 355 Death Benefit; 2) Truck Drivers and Helpers Local Union No. 355 Health and Welfare Fund. This form has three sections. The first section requests general information about you. The following sections request that you designate a beneficiary for each benefit. If you designate more than one beneficiary, and the total percentages is not 100%, the distribution will be divided equally among those designated. You must notify the Funds immediately if your marital status changes. **This form MUST be signed and on file with the Fund Office to be effective.**

Section I – Personal Information Date of Hire: ____________________________

________________________________ ________________________________ ____________
Last Name First Name Middle Initial

_______________________ _________________
Social Security Number Date of Birth

____ ____________________________
Street Address City, State, Zip

_________________ Marital Status (Check One) ___Single ___Married ___Divorced
Home phone number

Section 2 – Truck Drivers and Helpers Local Union No. 355 Enrollment Card
****Note – In order to add a spouse we must have a copy of your marriage certificate. In order to add a child(ren) we must have a copy of their State issued birth certificate.*

Please list you dependents in the spaced below

Name	Social Security No.	Relationship	Date of Birth

Section 3 – Beneficiary Designation

I hereby designate the following person or persons as my beneficiary (ies) to receive benefits, if any, payable at my death from the Truck Drivers and Helpers Local Union No. 355 Health and Welfare.

Name:________________________________
Address: ______________________________
____
SSN: __________________DOB_________
Relationship:___________Percent_________

Name:__________________________________
Address:________________________________
____
SSN: _____________________DOB:________
Relationship:______________Percent________

Name:_______________________________
Address: ____________________________
____
SSN: __________________DOB_________
Relationship:___________Percent_______

Name:__________________________________
Address:________________________________
____
SSN: _____________________DOB:________
Relationship:______________Percent________

Contingent Beneficiary Designation:

Name:_____________________________
Address: ___________________________
____
SSN: __________________DOB_________
Relationship:___________Percent_______

Name:_______________________________
Address:_____________________________
____
SSN: _____________________DOB:________
Relationship:______________Percent_____

Name:_____________________________
Address: ___________________________
____
SSN: __________________DOB_________
Relationship:___________Percent_______

Name:_______________________________
Address:_____________________________
____
SSN: _____________________DOB:________
Relationship:______________Percent_____

I hereby make the designation of beneficiary for each of the benefits specified above and revoke any previous designations. I understand that the beneficiaries named above may be revoked at any time by filing a new designation in writing on the Fund office's form. I understand that if all of the above designated beneficiaries predecease me, the distribution will be made in accordance with the terms of the Plan. **I agree to notify the Fund Office immediately of any change in my marital status.**

____ ___________________
Signature of Participant Date

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Declaration of Health Insurance

The form below is intended to solicit information concerning other Medical Benefits which may be available to your spouse or dependent children. If that other coverage is Primary to the Fund, having this information on file will help ensure the accurate payment of the claim and also maximize the benefit dollars available from your Health Fund. This information is required to be updated every 18 months. Please complete the form and return it to the Fund Office. Your assistance in this process is appreciated.

☐ Check here if **NO OTHER COVERAGE** available to you, your eligible spouse and/or dependents and sign & date this form at the bottom.

- OR -

If you, your spouse and/or dependent children have other coverage, **please complete the form below and return with a copy of the other carrier's identification card.**

Other Coverage Carrier Name ______________________

Policy Holder's Name ______________________

Type of policy (Retiree plan, Active plan etc.) ______________________

Effective date ______________

List who is covered and relationship to policy holder ____

Type of Coverage (Check all that apply)

☐ Medical ☐ Dental
☐ Vision ☐ Prescription Drug

Other Coverage Carrier Name ______________________

Policy Holder's Name ______________________

Type of policy (Retiree plan, Active plan etc.) ______________________

Effective date ______________

List who is covered and relationship to policy holder ____

Type of Coverage (Check all that apply)

☐ Medical ☐ Dental
☐ Vision ☐ Prescription Drug

Important: If the other coverage terminates, the Fund requires a copy of the HIPPA notice issued from the other carrier. This notice is required to be mailed upon termination.

______________________	______________________	______________	______________
Print Name	Member Signature	Date	SS#