# I.B.E.W. Local 688

33 Fitch Blvd
Austintown, Ohio 44515

Telephone: 1-800-435-2388
330-270-0453

## Enrollment Form

If this form is to change current information, mark type of change below:

Add dependents_____ Change address _____ Delete Dependents_____

Change Beneficiary _____

Please complete and return this form to assure enrollment or that your changes are processed. If additional documentation or information is needed, you will be notified:

Local Number: _____

**Member Name**: _____

Social Security: _____

Address: _____

_____

Phone Number: _____

Date of Birth: _____

Sex: _____

Marital Status: _____

**Spouse Name**: _____

Date of Marriage: _____

Social Security No. _____

Date of Birth: _____

Sex: _____

**Dependent Name**: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

**Dependent Name**: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

**Dependent Name**: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

Are any family members covered by another group health plan? ___Yes _____No

Name of Company :_____

Policy Holder's Name: _____

## DEATH BENEFIT INFORMATION

Name of Beneficiary _____SSN#:_____

Relationship:_____

Address:_____

Intentionally withholding or falsifying information requested on the form may result in loss of coverage for you and your dependents.

Member Signature:_____Date:_____