Insurance & Pension Funds
of Roofers Local No.241

890 Third Street
Albany, New York 12206
Telephone: 518-489-3919

FUND PARTICIPANT'S INFORMATION

Participant's Name: _____

Participant's Social Security Number: _____ - _____- _____

Participant's Home Address: _____

Participant's Date of Birth: _____/_____/_____

Participant's Home Phone: _____-_____-_____ Cell: _____-_____-_____

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

If applicable, please complete the following section regarding your spouse.

(Please complete the following information about your spouse and provide proof of marriage.)

Spouse's Name: _____

Spouse's Social Security Number: _____ - _____- _____

Spouse's Date of Birth: _____/_____/_____

Date of Marriage: _____/_____/_____

If your spouse is currently employed, please provide the complete name and address of his/her employer: Employer Name: _____

Employer Address: _____

If your spouse's Employment provides medical coverage for you/dependents, provide carriers name and proof of coverage: Insurance Company:_____

Participant Signature: _____Date: ____/____/_____

Spouse Signature: _____Date: ____/____/_____

DEPENDENT'S INFORMATION

(Please complete the following information on all children, less than 26 years of age that you are claiming as eligible dependents and provide proof of Parental/Guardianship.)

Name	D.O.B.	SSN#	Relationship

BENEFICIARY DESIGNATIONS

(YOU MUST SIGN AND DATE THIS FORM IN ORDER TO LEGALLY DESIGNATE YOUR BENEFICIARY)

I want the following spouse/child/children listed as my beneficiary for the medical death benefit, which may be provided in accordance with the Insurance & Pension plans of Roofer's Local 241. In the event that a qualified participant dies without naming a beneficiary or should the named beneficiary pre-decease the qualified participant, then any death benefit will be paid to his/her estate.

*(Note: **Both** beneficiaries, Primary and Contingent, **MUST** be a spouse or child)*

PRIMARY BENEFICIARY FOR YOUR MEDICAL ACCOUNT

Your **Primary** beneficiary is a person that would get the use of this account, if you are deceased.

Full Name of Beneficiary (spouse/child/children): _____

_____

Beneficiary Home Address: _____

Beneficiary Contact Phone: _____-_____-_____

Relationship to Participant: ☐ Spouse ☐ Son ☐Daughter

CONTINGENT BENEFICIARY FOR YOUR MEDICAL ACCOUNT

Your **Contingent** beneficiary is a person that would get the use of this account, if your Primary beneficiary you designated is deceased.

Full Name of Beneficiary (spouse/child/children): _____

_____

Beneficiary Home Address: _____

Beneficiary Contact Phone: _____-_____-_____

Relationship to Participant: ☐ Spouse ☐ Son ☐ Daughter

I understand this will supersede any previous beneficiary designations which I have made to the Insurance & Pension Plans of Roofer's Local #241. I also reserve the right to change my beneficiary or beneficiaries at any future date.

Participant Signature: _____Date: ____/____/_____

Witness Signature: _____ Date: ____/____/_____

PRIMARY BENEFICIARY FOR YOUR PENSION PLAN

Your **Primary** beneficiary is a person that would get the use of this account, if you are deceased.

Full Name of Beneficiary (spouse/child/children): _____

_____

Beneficiary Home Address: _____

Beneficiary Contact Phone: _____-_____-_____

Relationship to Participant: ☐ Spouse ☐ Child ☐Other _____

CONTINGENT BENEFICIARY FOR YOUR PENSION PLAN

Your **Contingent** beneficiary is a person that would get the use of this account, if your Primary beneficiary you designated is deceased.

Full Name of Beneficiary (spouse/child/children): _____

_____

Beneficiary Home Address: _____

Beneficiary Contact Phone: _____-_____-_____

Relationship to Participant: ☐ Spouse ☐ Child ☐ Other _____

I understand this will supersede any previous beneficiary designations which I have made to the Insurance & Pension Plans of Roofer's Local #241. I also reserve the right to change my beneficiary or beneficiaries at any future date.

Participant Signature: _____Date: ____/____/_____

Witness Signature: _____ Date: ____/____/_____

YOUR IMMEDIATE COOPERATION IS REQUIRED IN COMPLETING THESE FORMS. THESE FORMS ARE SPECIFICALLY DESIGNED FOR THE PROTECTION OF YOUR BENEFITS UNDER THE INSURANCE & PENSION FUNDS OF ROOFER'S LOCAL #241. THESE FORMS WILL BE YOUR PERMANENT RECORD AT THE FUNDS OFFICE, SO PLEASE ANSWER ALL QUESTIONS AND RETURN THE COMPLETED AND SIGNED FORMS TO THE FUNDS OFFICE AT THE ADDRESS LISTED ON THE FIRST PAGE OF THIS FORM.

IF AT ANY TIME, YOU WISH TO CHANGE ANY DESIGNATION OF BENEFICIARY, PLEASE CONTACT THE FUNDS OFFICE TO FILL OUT A NEW FORM.