Ullico

SOLUTIONS FOR THE UNION WORKPLACE

ENROLLMENT AND BENEFICIARY FORM

PLEASE PRINT

INSTRUCTIONS: This form is to be utilized for enrollment and beneficiary purposes only. All correspondence and questions should be addressed to the Fund/Employer maintaining your eligibility information.

- **For all new additions and reinstatements, complete the entire form, and sign at the bottom.**
- **For all other needs, complete the appropriate section, and sign at the bottom.**

Please check: ☐ **New enrollment** ☐ **Reinstatement** ☐ **Address Change** ☐ **Beneficiary Change**

SECTION A – Policyholder Information

Name of group policyholder: **Great Plains Laborers' District Council** Policy number: **G - 3254**

Effective date: **07/01/2014** Local/Bill ID: _____

SECTION B – Insurance Amount

Life amount: $ **2,000.00** AD&D amount: $ **2,000.00** AH amount: $ _____ LTD amount: $ _____

Billing classes: _____ _____ _____ _____

☐Duplicate certificate request

SECTION C – Insured Information

☐ Male ☐ Female

☐ Active ☐ Retiree

Name of insured: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Date of birth: _____

Occupation: _____ Weekly earnings: _____ Date started working: _____

SECTION D – Beneficiary

NOTE: If the beneficiary is being changed, the new beneficiary will replace all prior designations and will be effective as of the date this form is signed.

Beneficiary name	Relationship to Insured	Date of birth	% of share	SSN:
Primary: 1.			%	
2.			%	
Contingent: 1.			%	
2.			%	

INSURED SIGNATURE (Required): X _____ Date: _____

WITNESS SIGNATURE (Required for new adds, reinstatements or beneficiary change): X _____ Date: _____

PLEASE READ AND COMPLETE ALL PAGES

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FRAUD NOTICE

California: For your protection California Law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits

I attest that I have reviewed, understand and acknowledge the fraud warning(s).

Member or Claimant's signature: X _____ Date: _____

PLEASE READ AND COMPLETE ALL PAGES

BENEFICIARY DESIGNATION FOR $20,000 POLICY

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Policyholder: Laborers' International Union of North America (LIUNA)

Policy No.: 59-ADD-S01211

Insured person's name: _____

Death benefits to be paid to beneficiary named below. State relationship.

Name: _____ Age: _____ Relationship: _____ %: _____

Name: _____ Age: _____ Relationship: _____ %: _____

And the right to change the beneficiary(ies) without the consent of the said beneficiary(ies) is reversed.

Signature: _____ **Date:** ____/____/____

NAMING THE BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. If you need assistance, contact the union hall.

The following are the most common designations:

- Mary J. Doe, Wife (Not Mrs. John Doe)
- Mary J. Doe, if living, otherwise to Joseph W. Doe, Son
- Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joseph W. Doe, Son, in equal shares or to the survivor.
- Estate of the Insured Person

If you name more than one beneficiary with unequal share, please show the amount of insurance to be paid to each beneficiary in fractional parts; for example, "1/3 to Mary Jones, Mother, and 2/3 to Edith Jones, Wife."

Please state age and relationship of each beneficiary. If the beneficiary is not related to you either by blood or marriage, insert the words "Not related," and state the address of the beneficiary.

The signature must be in ink. Do not erase or use white-out. If corrections are needed, cross out the error and initial the correction.

The completed form should be submitted to:

LiUNA! LOCAL 177
Feel the Power

LABORERS' INTERNATIONAL UNION
OF NORTH AMERICA, LOCAL 177
3400 E Euclid Ave, Suite A
Des Moines, IA 50317

THE HARTFORD