BRICKLAYERS & ALLIED CRAFTWORKERS, JOINT BENEFIT FUND
300 Centre Drive
Albany, New York 12203
EMPLOYEE DATA SHEET
SIDE I – EMPLOYEE INFORMATION

This form is specifically for the protection of your benefits and will be your permanent record. Please be sure you fill in all personal information called for on both **Side I and Side II.** Return this completed and signed form to the Fund Office at the above address. **PLEASE PRINT ALL INFORMATION.**

_____

Last Name First Name M.I. Date of Birth

_____

Street Address City State Zip Code

_____ _____

Social Security Number Area Code and Phone Number

Single ( ) Married ( ) Re-married ( ) Divorced ( ) Widowed ( )

Is Member covered under another group medical plan? ( ) Yes ( ) No
If **"YES"** indicate name and address of insurance carrier through which medical coverage is provided.
Name: _____
Address: _____
Effective Date: _____

BENEFICIARY DESIGNATIONS
BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 2 HEALTH BENEFIT

******Primary Beneficiary's Name: _____ Date of Birth: _____
Address & Phone Number: _____
Social Security Number: _____ Relationship: _____

**Secondary Beneficiary's Name: _____ Date of Birth: _____
Address & Phone Number: _____
Social Security Number: _____ Relationship: _____

BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 2 PENSION FUND
In accordance with Federal Law, if you are a vested Participant "Beneficiary" means your lawful spouse or, if there is no lawful spouse, the person you specify as your Designated Beneficiary under the Health Benefit Fund above.

BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 2 ANNUITY FUND
Under the Plan "Beneficiary" means your spouse, or if there is no spouse, then the person or persons you have specified in writing as your Designated Beneficiary. Your spouse must consent in writing, witnessed by a notary public, to your designation of a non-spouse Beneficiary in order to have the Death Benefit paid to a Designated Beneficiary.

EMPLOYEE'S CERTIFICATION
I understand that this will cancel out any previous beneficiary designation or designators which I have made. I reserve the right to change my beneficiary or beneficiaries at any future date. I certify that all information provided on this form is true and correct. I understand and agree that any false information may disqualify me for benefits and that the Fund Office shall have the right to recover any benefit payments made because of such false information.

_____ _____

Employee's Signature Date Signed

YOUR PRESCRIPTION CARD CANNOT BE ORDERED UNTIL WE RECEIVE THIS INFORMATION SHEET & REQUIRED DOCUMENTATION

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SIDE II – EMPLOYEE INFORMATION

See attached **Dependent Documentation Sheet** as to what you, the Employee, must furnish for each of the Dependent's listed below. **Dependent claims submitted without proper documentation will be delayed for payment until the Fund Office can determine whether Dependent coverage is valid.**

Part A - List your lawful spouse and unmarried dependent children who are under age 19.

	First/Last Name	Birth Date - Month/Day/Year	Relationship - Spouse/Son/Daughter	Social Security Number
Spouse:	_____	_____	_____	_____
Child #1:	_____	_____	_____	_____
Child #2:	_____	_____	_____	_____
Child #3:	_____	_____	_____	_____
Child #4:	_____	_____	_____	_____
Child #5:	_____	_____	_____	_____
Child #6:	_____	_____	_____	_____
Child #7:	_____	_____	_____	_____

Part B - List your unmarried dependent children who are 19 to 24 years of age attending college as a **Full – Time Student.**

First/Last Name	Birth Date - Month/Day/Year	Relationship - Spouse/Son/Daughter	Social Security Number
_____	_____	_____	_____
_____	_____	_____	_____

Part C -
Spouse's Employment: ( ) None ( ) Full-Time ( ) Part- Time
Employer's Name: _____
Street Address: _____
City, State, Zip Code: _____

Is your spouse covered under his/her employer's medical plan? ( ) Yes ( ) No
Is your spouse covered under his/her employer's prescription plan? ( ) Yes ( ) No

If **"YES"** indicate name and address of insurance carrier through which medical/prescription coverage is provided.
Name and Address: _____
Effective Date of Coverage: _____ ( ) Individual ( ) Family

If **"NO"** did your spouse elect to **"Waive-out"** or **"Opt-out"** of the:
( ) Individual Coverage ( ) Family Coverage ( ) Both Individual and Family Coverage?