

## Enrollment Form for the West Virginia Laborers' Insurance and Pension Trust Fund

Please complete this document and mail it to our office at: 1 Union Square, Suite 200, Charleston, WV 25302. You may fax it to 304-342-2610. You may also fill out the online Enrollment Form through our Participant Portal at <http://www.wvlaborers.com/>. If you are mailing in the form, please provide a copy of the following documents for us to process your, and any applicable dependents', health insurance eligibility, pension eligibility, and annuity eligibility (if applicable).

- |   |   |
|---|---|
| <input type="checkbox"/> Marriage Certificate (if you are married)<br><input type="checkbox"/> Legal Divorce Documents (to remove ex-spouse from pension) | <input type="checkbox"/> Birth Certificates (for all children you want covered)<br><input type="checkbox"/> Adoption Affidavit (for any adopted or stepchildren you want covered) |
|---|---|

Full Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Mailing Address: \_\_\_\_\_

Select one: \_\_\_\_\_ Local Union\* No. \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Local Entry Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone Number (Select one: \_\_\_\_\_ ): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

Participant's Signature: \_\_\_\_\_

### Designation of Beneficiary\*:

Full Legal Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Mailing Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\*Please note that if you are married and have designated someone other than your spouse to receive your death benefits, the Plan cannot honor your designation unless both you and your spouse complete additional documentation. Please contact the Fund Office at 304-342-5142 for more information. You may change your beneficiary at any time by providing the proper documentation.

For health insurance coverage, list below the information for your spouse and all dependents under 26 years of age.

| Name | Relationship | Social Security # | Date of Birth |
|------|--------------|-------------------|---------------|
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|      |              |                   |               |
|      |              |                   |               |
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\*If you are a member of an out-of-state local, please contact the Fund Office to complete the appropriate reciprocal documents.