

**ENROLLMENT FORM
NATIONAL ELEVATOR INDUSTRY BENEFIT PLANS**

Complete and Return to:
National Elevator Industry Benefit Plans
19 Campus Blvd, Ste 200
Newtown Square, PA 19073-3288

Emai: eligibility@neibenefits.org

Fax: 610-325-9028

(Not to be used for Elevator Constructors Annuity and 401(k) Plan)

| EMPLOYEE INFORMATION | | | |
|----------------------|----------------|----------------|-------------------|
| Employee Name | | Gender | Social Security # |
| Street Address | City | State | Zip Code |
| Home Phone # | Cell Phone # | E-mail Address | |
| Birth Date | Marital Status | Hire Date | Union Local # |

| Select All that Apply | | |
|---|--|--|
| (Must provide required documentation for dependent changes per attached instructions) | | |
| <input type="checkbox"/> Helper - New to Trade | <input type="checkbox"/> Active Employee | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Address Change | <input type="checkbox"/> Dependent Add or Change | <input type="checkbox"/> Beneficiary Add or Change |

| ELIGIBLE DEPENDENTS | | | | | | |
|---|------------|------|---------------|--------|---------------|--------------|
| Failure to list eligible dependents and to supply required documentation may result in a denied Health Benefit Plan claim. False information may result in loss of eligibility and/or prosecution. (See necessary documentation on attached instructions) | | | | | | |
| Last Name | First Name | M.I. | Soc. Sec. No. | Gender | Date of Birth | Relationship |
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| BENEFICIARY INFORMATION | | | | |
|-------------------------|-----|---------|---------|--------------|
| Name | SSN | Phone # | Share % | Relationship |
| Address | | City | State | Zip |
| Name | SSN | Phone # | Share % | Relationship |
| Address | | City | State | Zip |

(FOR ADDITIONAL AND/OR CONTINGENT BENEFICIARIES USE SEPARATE SHEET)

I hereby designate the above to be beneficiary(ies) of any benefits due from the National Elevator Industry Pension Plan and National Elevator Industry Health Benefit Plan in accordance with Plan rules. This designation revokes any prior designation inconsistent herewith. I reserve the right to change a beneficiary designation at my discretion and understand that any change is not effective unless this form is properly completed and received by the Benefits Office. If more than one beneficiary is named, payment shall be made to each in equal shares unless otherwise indicated in Share %'s. The total of all Share %'s must equal 100.

| | | | |
|-----------------------------|--|-------------|--|
| § EMPLOYEE SIGNATURE | | DATE | |
|-----------------------------|--|-------------|--|

INSTRUCTIONS

Attach a **copy** of the appropriate documents as set forth below:

| TO ADD DEPENDENT | | |
|---|--|--|
| DEPENDENT TYPE | DOCUMENT(S) REQUIRED | NOTES |
| Natural Child (under age 26) | Birth Certificate | Must be state issued birth certificate which lists both parents' full name. |
| Spouse | Birth Certificate Marriage Certificate | Must be a state issued birth certificate. Must be a marriage certificate, not a marriage license. |
| Stepchild (under age 26) | Birth Certificate Stepchild Affidavit Other Coverage | Must be a state issued birth certificate. Go to www.neibenefits.org then Resources/Forms section. Note name of other health coverage provider, policy holder and policy holder ID#. |
| Adopted Child | Birth Certificate Adoption Decree | Must be a state issued birth certificate which lists both parents' full name. Adoption Decree or proof that child has been placed with you for adoption. |
| Permanent Dependent Child | Birth Certificate Doctors Letter | Must be a state issued birth certificate which lists both parents' full name. Letter from doctor stating child is incapable of self-support due to physical or mental disability within 31 days of child's 26th birthday. |
| Additional Dependents or Beneficiaries | Additional Sheet of Paper | Print, scan and attach additional dependent/beneficiary information that does not fit on first page of Enrollment Form. |

| TO REMOVE DEPENDENT | | |
|----------------------------|--|--|
| DEPENDENT TYPE | DOCUMENT(S) REQUIRED | NOTES |
| Spouse | Divorce Decree Settlement Agreement | Must be full divorce decree filed by court. Include any Property Settlement Agreements. |
| Deceased Dependent | Death Certificate | Must be copy of certified death certificate. |

ADDITIONAL INFORMATION

- A former spouse becomes ineligible upon the last day of the calendar month in which the divorce becomes final. The Benefits Office must receive the divorce decree within 60 days of divorce in order to offer COBRA Continuation Coverage. If you do not notify the Benefits Office when you divorce, you will be responsible for reimbursing the Plan for all charges that were paid by the Plan on behalf of your former Spouse while he or she was not eligible for coverage. Any stepchild(ren) associated with the former spouse will also be removed the same day as the former spouse.
- Your natural child will be covered for first 90 days from birth without a birth certificate.
- List all current eligible dependents when adding a new dependent.
- Complete the entire beneficiary section even if the information remains the same.
- Only attach copies of required documents above. Original documents will not be returned.
- Enrollment form must be completed and received by the Benefits Office in order to become effective.
- Any Foreign documents must be translated in English.

ANY PERSON WHO FILES THIS FORM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY LOSE NEI BENEFIT COVERAGE.