



Application to Union’s Insurance Program
\$10,000 Life insurance for members in good standing

PLEASE PRINT – All information is confidential

Local No. _____

Name of Your Employer _____ Dept. _____

Your Name _____ Male _____ Female _____

Social Security Number _____ Date of Birth _____ Hire Date _____

Mailing Address _____

Street _____ Primary Phone No. _____ Apt # _____
City _____ State _____ Zip _____

Personal Email _____

Hours Worked Per Week _____ Annual Salary _____ Marital Status _____

If Mailing Address is a PO Box – Please Fill Out Street Address Below:

County You Live In _____ Legislative District (If known) _____

Beneficiary Information

Name of Beneficiary _____ (Must have full name, i.e.: Mary A. Doe, NOT Mrs. John J. Doe)

Date of Birth _____ Relationship to you _____

Address of Beneficiary _____

Your Work Information

Work Mailing Address _____

Work Phone _____

Work Email _____

Employer Name _____ Dept. _____

Employee Signature _____ Date _____

Please note: all information must be completed to insure coverage.