FRINGE BENEFIT ENROLLMENT FORM
I.B.E.W. LOCAL UNION 269
PRINT ALL INFORMATION

Last Name | *First Name* | *M.I.* | *Social Security Number*

Home Address | *City* | *State* | *Zip*

Home Phone # | *Cell #* | *E-mail Address*

Date of Birth | *Marital Status (Circle One)* *Single* *Married* *Divorced* *Widowed* | *Date of Marriage*

List Below Names of Your Spouse and All Dependent Children (up to age 26)

List Names in Order of Age – Oldest First	*Social Security No.*	*Check Relationship* *Spouse*	*Son*	*Daughter*	*Date of Birth* *Month*	*Day*	*Year*

Beneficiary Designations

I hereby authorize the payment of any death benefits as follows:

	Primary		***Contingent***	
Welfare Fund	*Name (Last, First, MI)*		*Name (Last, First, MI)*	
	Address		*Address*	
	SSN	*Relationship*	*SSN*	*Relationship*
Pension Fund	*Name (Last, First, MI)*		*Name (Last, First, MI)*	
	Address		*Address*	
	SSN	*Relationship*	*SSN*	*Relationship*
Annuity Fund	*Name (Last, First, MI)*		*Name (Last, First, MI)*	
	Address		*Address*	
	SSN	*Relationship*	*SSN*	*Relationship*

Signature of Employee | *Date*

Spousal Consent

If you are married and you wish to name someone other than your spouse as the beneficiary to your pension or annuity benefits, your spouse must consent to your designation by signing below in the presence of a Notary Public. YOUR BENEFICIARY DESIGNATION WILL NOT BE VALID UNLESS YOUR SPOUSE'S SIGNATURE IS NOTARIZED.

As the lawful spouse of the herein-named participant, I hereby certify that I agree with the pension and annuity beneficiary designation(s) made above. I understand that by doing so, I waive any and all rights to my spouse's death benefits and authorize the Administrator of the IBEW Local Union 269's Funds to pay all death benefits to the above named beneficiary(ies).

(Signature of Participant's Spouse)

NOTARY

State of _____)
) SS:
County of _____)

Subscribed and Sworn to before me, this _____ day of _____, 20 _____.

(Notary Public)

Dear Participant:

Please complete the Fringe Benefit Enrollment Form on the reverse side and return it to our office. This form must be *signed and dated in order to be valid*.

The following documentation is ***required*** for you and your eligible dependent(s).

Married- Please provide a copy of your state issued marriage certificate.

Children – Please provide a copy of each child's state issued birth certificate.

Stepchildren, adopted children and foster children- Please provide a copy of each dependent's state issued birth certificate along with applicable documentation (i.e. adoption papers, court documents, a copy of last year's federal income tax return and a letter certifying that the other biological parent is not responsible for their coverage and that you will be claiming them as your dependent on your income tax return.)

Divorce – Please provide a copy of your divorce decree.

Legible Copies of Social Security Cards - for yourself and each of your eligible dependent(s).

Under the Affordable Care Act (ACA), all individuals are required to maintain health insurance coverage. The Plan is required to provide you with a 1095B form detailing who in your family has received coverage from the Welfare Fund. The IRS requires an exact match on the spelling of each name and Social Security number, as indicated on the Social Security cards for you and each of your eligible dependents. If there is any deviation, the IRS will reject the submission of your 1095 B information. ***Failure to provide correct information could result in the IRS accessing penalties to you when you file your income taxes.***

Should you have questions relative to completing this form or the documentation required, please feel free to contact our enrollment department at 1-800-792-3666 extension 6005.

Return completed form with documentation to:

I E Shaffer & Co
PO Box 1028
Trenton NJ 08628