UNITED FURNITURE WORKERS INSURANCE FUND

1910 AIR LANE DRIVE - NASHVILLE, TENNESSEE 37210

ENROLLMENT FORM

(PLEASE PRINT CLEARLY)

Last Name _____ First Name _____ Mid. Init. _____

Home Address/Telephone No. E-mail address _____

Street _____ City _____

State _____ Zip _____ Telephone No. ( ) _____

Social Security # _____ Date of Birth _____

Gender: [ ] Male [ ] Female

Marital/Relationship Status: [ ] Single [ ] Married [ ] Divorced [ ] Domestic Partnership

*In the event that Enrollee is engaged in a Domestic Partnership, Enrollee must complete an Affirmation of Domestic Partnership form and any other forms required by the Fund.

Employer's Name _____ Local # _____

Date of Hire _____

TYPE OF COVERAGE YOU ARE SELECTING:

[ ] Single [ ] Employee + Spouse/Domestic Partner [ ] Employee + Child(ren) [ ] Family

My Death Benefit (if applicable) is to be paid to:

Name: _____ Relationship _____

Enrollee Signature X _____

NAME(S) OF DEPENDENT(S)

Examples of Dependents may include husband, wife, domestic partner, and/or children. Please list all dependent children under age 26 that you wish to include for coverage. The Fund may require additional information on your dependent children and you will be notified accordingly.

Name of Dependent	Gender	Dependent's Social Security #	Dependent's Relationship to Enrollee	Dependent's Date of Birth	Marital Status

The reverse side must be completed if you are including dependents on your coverage

EMPLOYER INFORMATION FOR SPOUSE OR DOMESTIC PARTNER

PLEASE PROVIDE THE FOLLOWING INFORMATION IF APPLICABLE

Name of Spouse or Domestic Partner

Last Name_____ First Name_____ Gender [ ] Male
[ ] Female

Employer for Spouse or Domestic Partner

Employer Name _____

Employer's Telephone # ( ) _____

Employer Address - Street _____ City _____

State _____ Zip _____

Insurance Company for Employer of Spouse or Domestic Partner

Insurance Company Name _____

Insurance Company Telephone # ( ) _____

Insurance Company Address:

Street _____ City _____

State _____ Zip _____

Type of Coverage [ ] Single [ ] Family [ ] Other (Specify) _____

Policy I.D. # _____ Effective Date of Coverage _____

Please check ALL coverages provided by Insurance Company for Spouse or Domestic Partner

[ ] Medical [ ] Prescription Drug [ ] Chiropractic [ ] Dental [ ] Vision

*If any of the Dependents listed are the Enrollee's natural children or step-children from a previous marriage, the Enrollee must submit a copy of the Divorce Decree stating which parent or step-parent has custody of the children and which parent or step-parent has financial responsibility for the medical expenses of such children. In the event that any of the Dependents listed above are the Enrollee's natural children or step-children from a previous domestic partnership, the Enrollee must submit a copy of a legal document containing the custodial and financial responsibility information referenced above. If one particular parent or step-parent is responsible for the medical expenses of the children, the Enrollee must provide the name and address of the insurance carrier that presently covers the children.

Name of Parent with Primary Custody _____

Name of parent having primary financial responsibility for medical coverage, as determined by Divorce Decree (in the case of a previous marriage) or corresponding legal document (in the case of a previous domestic partnership) _____ (The Fund may request a copy of the Divorce Decree or Court Order.)

Name, Address, and Telephone Number of Insurance Carrier providing Primary Coverage:

Insurance Company Name _____

Street _____ City _____

State _____ Zip _____

Insurance Company Telephone # ( ) _____