The Joint Industry Board of the Electrical Industry
158-11 Harry Van Arsdale Jr. Avenue • Flushing, NY 11365-3095
Tel: (718) 591-2000 | Fax: (718) 380-7741 | www.jibei.org

Dear Participant:

The Joint Industry Board administers several benefits that will cover you and eligible dependents. You may participate in some or all these plans. Please keep the enclosed Summary Plan Descriptions (SPD's) in a safe place. You can obtain additional information and access the Summary Plan Description for each benefit plan by visiting www.JIBEI.org website.

A. Pension, Hospitalization and Benefit Plan of the Electrical Industry - Health and Welfare Plan; Health Reimbursement Account Plan of the Electrical Industry

Eligible dependents are: 1) spouse and 2) children (natural, legally adopted and stepchildren) from birth up to their 26th birthday, regardless of marital or student status.

B. Dental Benefit Fund of the Electrical Industry or Dental Benefit Plan of the Elevator Division

Eligible dependents are: 1) spouse and 2) unmarried children from birth up to their 19th birthday (natural or legally adopted children). However, full-time, unmarried dependent students attending accredited institutions of higher learning shall be covered up to age 26 years. An original letter from the college registrar for the current semester shall be required as proof of current college attendance. The term "children" shall mean natural or legally adopted children. Dental COBRA coverage can be purchased for stepchildren.

C. Pension, Hospitalization and Benefit Plan of the Electrical Industry– Pension Trust Fund; Annuity Plan of the Electrical Industry; Deferred Salary Plan of the Electrical Industry

These plans provide valuable benefits for your retirement.

Proper recording your eligible dependents and any other health coverage available to them ensure the timely processing of future claims. Please complete the enrollment form and return it along with copies of the required documentation, including Social Security cards, marriage certificate, birth certificates and/or adoption papers. This information is necessary to accurately record and enroll your eligible dependents in the Plan.

Please submit the completed form and supporting documentation using one of the following methods:

By Mail:
Joint Industry Board of the Electrical Industry
Attn: Members Records Department
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365
By Email: Membersrecords@jibei.com
By Fax: 718-591-2189

Sincerely,
Members Records Department

Pension, Hospitalization and Benefit Plan of the Electrical Industry
158-11 Harry Van Arsdale Jr. Avenue, Flushing NY 11365
Members Records Dept. Phone: (718) 969-4030, Fax: (718) 591-2189

ENROLLMENT FORM

SECTION 1: PARTICIPANT INFORMATION:

Last Name_____ First Name_____

Assigned Sex at Birth: M ☐ F ☐ Current Sex: M ☐ F ☐ Other ☐

PID/Social Security # _____ Marital Status_____

Email_____Date of Birth_____

Address_____

Home Telephone_____Cell Phone _____Email_____

Enrolled in **another health plan?** Yes ☐ No ☐ **If yes, complete section 3.**

SECTION 2: DEPENDENT INFORMATION (If you are married, please attach a copy of your marriage certificate. For each dependent child, please attach a copy of the child's birth certificate and Social Security card.

1. Relation to Participant (Check One): ☐ Spouse Date of Birth: _____ ☐ Child Date of Birth: _____

Last Name_____First Name_____Social Security Number_____

Assigned Sex at Birth: M ☐ F ☐ Current Sex: M ☐ F ☐ Other ☐

Address_____

Enrolled in **another health plan?** Yes ☐ No ☐ **If yes, complete section 3.**

2. Relation to Participant: ☐ Child Date of Birth: _____

Last Name_____First Name_____Social Security Number_____

Assigned Sex at Birth: M ☐ F ☐ Current Sex: M ☐ F ☐ Other ☐

Address_____

Enrolled in **another health plan?** Yes ☐ No ☐ **If yes, complete section 3.**

3. Relation to Participant: ☐ Child Date of Birth: _____

Last Name_____First Name_____Social Security Number_____

Assigned Sex at Birth: M ☐ F ☐ Current Sex: M ☐ F ☐ Other ☐

Address _____

Enrolled in **another health plan?** Yes ☐ No ☐ **If yes, complete section 3.**

4. Relation to Participant: ☐ Child Date of Birth: _____

Last Name_____First Name_____Social Security Number_____

Assigned Sex at Birth: M ☐ F ☐ Current Sex: M ☐ F ☐ Other ☐

Address_____

Enrolled in **another health plan?** Yes ☐ No ☐ **If yes, complete section 3.**

SECTION 3: COORDINATION OF BENEFIT INFORMATION

If you or dependent(s) are enrolled in **another health plan**, please provide the details of that coverage below and attach a copy of the health insurance card (front and back).

Name of other Health Plan:_____

Name of Policy Holder: _____ DOB: _____

Type of Plan (check one): ☐ Individual ☐ Family

Name of Person(s) Covered: _____

Policy holder is (check one): ☐ Actively Working ☐ Retired ☐ Other (i.e. disabled)

Effective Date of Coverage:_____

SECTION 4: PARTICIPANT'S SIGNATURE.

Print Name_____Date_____

Sign Name_____

JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY
158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365

DESIGNATION OF BENEFICIARY

The purpose of this form is to allow you to name a beneficiary or beneficiaries to receive your benefits from the plans named below in the event of your death. In the event that you have an outstanding loan to the Educational and Cultural Trust Fund at the time benefits become payable to you or your beneficiaries, this Designation of Beneficiary form designates the Educational and Cultural Trust Fund to be your primary beneficiary up to the amount necessary to pay off any outstanding loans which exist at the time of your death. If you do not name a beneficiary **(see Part III on Page 3)**, the benefits will automatically be paid to your surviving spouse or to other priority survivors as determined by the plans.

All participants must also complete Part IV on Page 3 and have their signature notarized in order for the beneficiary designation to be valid.

Upon your death, the beneficiary or beneficiaries you name on this form will receive the benefits that you may have been entitled to in addition to any death benefits that are payable under any of the specified plans. If you name more than one beneficiary other than the Educational and Cultural Trust Fund, the benefits will be paid in equal shares to the named beneficiaries surviving at the time of your death.

CAUTION: If you are married and wish to name someone other than your spouse or someone in addition to your spouse as your beneficiary, you must acknowledge that this designation will affect the survivor annuity rights of your spouse and you must obtain the written consent of your spouse. **In this case, your spouse's signature must be notarized on Page 4, Part V.**

If, after you have submitted this form to the Plan Administrator, you become married or divorced or if you wish to change the beneficiary you named on this form, you must complete and submit a new Designation of Beneficiary Form.

The person(s) you name as your beneficiary may be entitled to receive disbursements from the following plans which are administered by the Joint Industry Board of the Electrical Industry:

Additional Security Benefits Plan	Educational and Cultural Plan
Annuity Plan	Deferred Salary Plan
Health Reimbursement Account Plan	Pension, Hospitalization & Benefit Plan (Fka. VHUP) (Account Balance Plan Only)

Please refer to your Summary Plan Description booklet for each plan for additional information concerning your rights and the benefits available to you under the Plans.

Part I **PERSONAL INFORMATION**

(Please complete all of the following requested information)

Print Participant's Name _____ PID No. _____

Street Address _____ Birth Date _____

City _____ State _____ Zip Code _____ Telephone Number _____

Email Address _____ Cell Phone _____

Local No. _____ Date Initiated _____

Division _____ Card No. _____

Present Employer _____

Part II (Please complete all of the following requested information)

Current **Marital Status:** (Check one)

( ) Married - Date of Marriage: _____ Spouse's Birth Date: _____
( ) Widow(er)
( ) Divorced - If divorced, indicate name of divorced spouse _____
Year of Divorce: _____
( ) Single

If you were divorced, is your ex-spouse entitled to any benefits pursuant to a Qualified Domestic Relations Order?
Yes ( ) No ( )

List Children: (Indicate if married by placing an "M" after the name)

	Child's Name	**Date of Birth**	**Social Security No.**
1.			
2.			
3.			
4.			
5.			
6.			

Part III

DESIGNATION OF BENEFICIARY

I hereby designate the Educational and Cultural Trust Fund, up to the amount of any outstanding loans I may owe, to be my primary beneficiary. For all funds over and above the amount necessary to pay off the loans, I hereby designate below the person(s) to receive the benefits from the plans administered by the Joint Industry Board of the Electrical Industry listed on page 1, which are payable upon my death subject to the terms of the plans. This designation supersedes any prior designations and shall remain effective until a subsequent Designation of Beneficiary Form, made in writing and signed by me, is received by the Plan.

Name	Address	Relationship	Date of Birth
_____	_____	_____	_____
Phone_____	_____	**Soc. Sec. No.**_____	

Name	Address	Relationship	Date of Birth
_____	_____	_____	_____
Phone_____	_____	**Soc. Sec. No.**_____	

Name	Address	Relationship	Date of Birth
_____	_____	_____	_____
Phone_____	_____	**Soc. Sec. No.**_____	

Part IV

PARTICIPANT'S STATEMENT

I have designated the person(s) named in Part III to be my beneficiary(ies) under the Plan(s) in which I participate. I understand that if I am married and have properly designated someone other than my spouse as beneficiary of the Plans indicated on page 1, no benefits will be paid to my spouse after my death other than those benefits which may be paid only to a surviving spouse under the provisions of certain Plans.

I also understand that if I am married and have designated a beneficiary in addition to or other than my spouse, this designation will be valid only if my spouse consents to it at the time this designation is made. To show consent, my spouse must sign page 4 on the line called "Spouse Consent Signature." This signature must be witnessed by a Notary Public. If I am currently unmarried and subsequently marry or remarry after being divorced, or upon the death of my spouse, I shall execute a new Designation of Beneficiary form and comply with the spousal consent requirements, if applicable.

Check one:
( ) I have designated my spouse as sole beneficiary. *(Page 4 need not be completed).*
( ) I am not legally married at this time.
( ) My spouse is deceased. *(Date of Death:* _____*)*
( ) My spouse has given consent on page 4 to the beneficiary (ies) named on page 3.
( ) I am unable to locate my spouse. *(Additional documentation must be submitted).*

I have read the foregoing statements and checked the appropriate statement and I agree to indemnify and hold harmless the fiduciaries of the Plans from any damages, fines, penalties and litigation costs incurred as a result of their actions taken in reliance upon the statements made herein.

_____ _____
(Participant's Signature) (Date)

State of)
)
County of)

On this day of , 20 before me came _____ , to me known and known to me to be the person described herein and who executed both the foregoing statement and Designation of Beneficiary and (s)he duly acknowledged to me that (s)he executed the same.

_____
(Notary Public)

Part V **SPOUSE'S CONSENT TO BENEFICIARY DESIGNATION**

I, _____ , swear that I am the legal spouse of

_____.
(Participant's Name)

I am aware that upon my spouse's death I am entitled to receive benefits that would have been payable to my spouse from the Plans listed on page 1. I understand if my spouse designated a beneficiary (see Part III) other than me or in addition to me to receive these benefits, the beneficiary designation is not valid unless I give my written consent to that beneficiary designation. If I give my written consent to the specified beneficiary designation, it is permanent and cannot be revoked by me at a later date. Any subsequent designation by my spouse of someone other than or in addition to me shall also be invalid unless I again give my consent to that particular beneficiary designation.

Being fully apprised of these facts, I hereby waive my rights to benefits, other than those benefits which may be paid only to a surviving spouse, payable under the Plans listed on page 1, and consent to (and only to) my spouse's designation of the Educational and Cultural Trust Fund up to the amount of any outstanding loans, as well as

_____, _____,
(List Name(s) of Beneficiary(ies)

_____ as beneficiary of the Plans indicated on page 1 of this form.

_____ _____
(Spouse Consent Signature) (Date)

State of)
)
County of)

On this day of , 20 , before me came _____
to me known and known to me to be the person described herein and who executed the foregoing Consent to Designation of Beneficiary and (s)he duly acknowledged to me that (s)he executed the same.

_____
(Notary Public)