

CWA LOCAL 1180 SECURITY BENEFITS FUND

6 Harrison Street 3rd Floor ■ New York, NY 10013-2898
Tel: 212-966-5353 ■ Fax 212-219-2450 ■ www.cwa1180.org



LIFE INSURANCE ENROLLMENT

Last Name MI First Name SSN

Address City State Zip Code

E-mail Gender: Female Male

Home Phone Mobile Phone Date of Birth
MM/DD/YYYY

Employing Agency

Beneficiary Designation

Primary (Please indicate Primary and Contingent Beneficiary)
 Unless otherwise stated the proceeds shall be divided equally among those of the following designated person(s) who survive the insured.

	Relp - Relationship		Total must equal to 100%
1. Name <input type="text"/>	Relp <input type="text"/>	SSN <input type="text"/> Phone <input type="text"/>	% <input type="text"/>
Address <input type="text"/> City <input type="text"/> State <input type="text"/> Zip Code <input type="text"/>			
2. Name <input type="text"/>	Relp <input type="text"/>	SSN <input type="text"/> Phone <input type="text"/>	% <input type="text"/>
Address <input type="text"/> City <input type="text"/> State <input type="text"/> Zip Code <input type="text"/>			
3. Name <input type="text"/>	Relp <input type="text"/>	SSN <input type="text"/> Phone <input type="text"/>	% <input type="text"/>
Address <input type="text"/> City <input type="text"/> State <input type="text"/> Zip Code <input type="text"/>			

Contingent
 Unless otherwise stated the proceeds shall be divided equally among those of the following designated person(s) who survive the insured, provided no primary beneficiary has survived the insured.

	Relp - Relationship		Total must equal to 100%
1. Name <input type="text"/>	Relp <input type="text"/>	SSN <input type="text"/> Phone <input type="text"/>	% <input type="text"/>
Address <input type="text"/> City <input type="text"/> State <input type="text"/> Zip Code <input type="text"/>			
2. Name <input type="text"/>	Relp <input type="text"/>	SSN <input type="text"/> Phone <input type="text"/>	% <input type="text"/>
Address <input type="text"/> City <input type="text"/> State <input type="text"/> Zip Code <input type="text"/>			

I UNDERSTAND THAT THIS COVERAGE SHALL BECOME EFFECTIVE ONLY IF YOU ARE ELIGIBLE FOR COVERAGE BY CWA LOCAL 1180 S.B.F.

Member's Signature Date

FOR LOCAL 1180 SECURITY BENEFITS FUND USE ONLY

Policy # **26 0B60**

Circle one: Full-Time Employee

Full-Time Employee

Date of Union Membership

Authorized Signature Date