MC DATE_____

for office use only

LINECO FAMILY ENROLLMENT CARD

Complete and return to:
LINECO
Line Construction Benefit Fund
821 Parkview Boulevard
Lombard, IL 60148-3230
1-800-323-7268

Please ***do not*** use abbreviations

Employee Name _____ Soc. Sec. #_____

Employee Address _____ Phone # (_____) _____
(Street #) (City) (State) (Zip Code)

Date of Birth _____ Sex: M or F (Circle One) Cell Phone # (_____) _____ Email Address _____

Marital Status: Single | Married | Divorced | Separated | Legally Separated | Widowed (Circle One)

Spouse Name _____ Date of Birth _____ Soc. Sec. #_____

**********Attach a CERTIFIED copy of the marriage certificate**********

Spouse employer name, address & phone number: If not employed, please indicate not employed: _____

_____

Dependent child / dependent child's spouse's employer name, address & phone # _____

_____

Does the employee or listed dependent(s) have medical, dental, drug coverage with anyone **other** than Lineco? YES | NO (Circle One)

If yes, provide the name, address, phone number and copy of ID card(s) of all coverages

_____

LIST ALL DEPENDENT CHILDREN UNDER AGE 26

Full Legal Name	Sex	Child's Relationship to you (natural child, stepchild, or other, please specify)	Social Security #	Birthdate	Employed Yes or No
1.					
2.					
3.					
4.					

FOR ANY CHILD LISTED ABOVE NOT BORN OF YOUR CURRENT MARRIAGE, SEE REVERSE SIDE.
SUBMIT COPIES OF THE DIVORCE DECREE OR COPIES OF ALL COURT DOCUMENTS RELATING TO THAT CHILD.
ANY MISSING INFORMATION WILL DELAY THE PROCESSING OF CLAIMS.

**********CALL THE FUND OFFICE FOR ALL ADDRESS AND PHONE NUMBER CHANGES**********

COMPLETE LIFE INSURANCE INFORMATION ON THE REVERSE SIDE

_____ _____
Date Signed **Signature of Employee**

PROVIDE NATURAL PARENTS' INFORMATION FOR EACH CHILD. INFORMATION SHOULD INCLUDE PARENT'S NAME, ADDRESS, PHONE NUMBER, BIRTHDATE, SOCIAL SECURITY NUMBER OR ID NUMBER, EMPLOYER NAME, ADDRESS, PHONE NUMBER, AND ALL INSURANCE INFORMATION WITH A COPY OF THE MEDICAL/DENTAL CARD(S). PROVIDE THE SAME INFORMATION FOR ALL STEP-PARENTS.

Child's Name _____ Relationship to Lineco Employee _____

Natural **Mother's** Name _____ Phone # (_____) _____
(if not Lineco Employee)

Address _____

Birthdate _____ Social Security/ID # _____

Employer Name _____

Address and Phone Number _____

Insurance Name _____

Address and Phone Number _____

Natural **Father's** Name _____ Phone # (_____) _____
(If not Lineco Employee)

Address _____

Birthdate _____ Social Security/ID # _____

Employer Name _____

Address _____ Phone # (_____) _____

Insurance Name _____

Address _____ Phone # (_____) _____

Who has physical custody of child? _____

*****LIFE INSURANCE BENEFICIARY INFORMATION*****

Employee Name _____ Soc. Sec # _____

Name of Beneficiary

_____
Last First Middle Initial Date of Birth Relationship

Beneficiary Address _____ Phone # (_____) _____

The above named beneficiary supercedes any and all beneficiaries previously designated. (Designation of a beneficiary will be valid only if the Fund Office receives this form while you (the employee) are still living.

_____ _____
Date Signed **Signature of Employee**