

MC DATE _____

for office use only

LINECO FAMILY ENROLLMENT CARD

Complete and return to:

LINECO

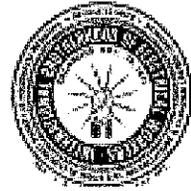
Line Construction Benefit Fund

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 Cell Phone # (____) _____ Email Address _____
(Circle One)

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