SOUTHEASTERN CARPENTERS AND MILLWRIGHTS HEALTH TRUST

Administered by Southern Benefit Administrators, Incorporated

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ENROLLMENT FORM

Please complete this form in its entirety, front and back and return it in the enclosed envelope. The information requested below is very important as it provides the Fund office with current information about you and your dependents. Please only list those dependents who meet the definition of an Eligible Dependent, as that term is defined in your Summary Plan Description. This form also allows you to designate a beneficiary for the purpose of receiving benefits from the Fund upon your death. Please sign and date the form.

The "Patient Protection and Affordable Care Act", a health care reform bill enacted by Congress and signed into law by the President in March 2010, provides that group health plans that cover dependent children must extend coverage for such dependents until attainment of age 26. In addition, a dependent child may not be excluded based on the following criteria: financial dependency, residency, student status, marital status, employment or eligibility for other coverage.

INFORMATION REGARDING YOU AND YOUR DEPENDENTS

Participant Name:_____ Date of Birth: _____Sex:_____

Address:_____City:_____State: _____

Zip Code:_____ Social Security No:_____ Local Union No._____

Participant's Email Address:_____ Phone Number:_____

Spouse's Email Address: _____ Phone Number:_____

Spouse's Name:_____Date of Birth: _____Sex:_____

Spouse's Social Security No.:_____ Date of Marriage:_____

Dependent Children:

Names:	Birthdate:	Social Security Number:	Relationship:	Sex:

DESIGNATION OF BENEFICIARY

Beneficiary Name:_____ Social Security Number:_____

Address (if different):_____

Contingent Beneficiary Name:_____ Social Security Number:_____

IF YOU OR A DEPENDENT HAVE OTHER HEALTH COVERAGE, COMPLETE THIS SECTION

Name of Covered Individual:_____

Group No:_____ Contract No.:_____

Name/Address of Insurance Company or Plan:_____

Telephone number of Insurance Company or Plan:_____

Effective date of coverage_____ Termination date of coverage (if applicable)_____

Type of coverage:_____Single _____ Family

_____ Medical _____ Dental _____ RX _____ Vision

Is your other coverage PPO or HMO? _____

IF YOU OR A DEPENDENT HAVE MEDICARE COVERAGE, COMPLETE THIS SECTION

Name of Covered Individual:_____

Medicare Health Insurance (HIC) Number:_____

Enrolled in:_____ Part A _____ Part B _____ Part D

Medicare Eligibility based on: _____ Age _____ Disability _____ End Stage Renal Disease

Signature:_____ **Date:**_____

THIS FORM MUST BE SIGNED AND DATED BY THE PARTICIPANT