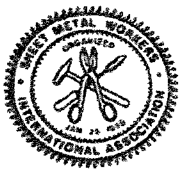

Sheet Metal Workers' Local 17
1157 Adams St., 2nd Floor
Dorchester, MA 02124
Phone: 617-296-1680

Life Insurance Enrollment & Beneficiary Form

Group Employee Enrollment Form for Local 17 Members

Completing Your **GROUP ENROLLMENT FORM** 1. **Fully complete** each section 2. **Sign and date**	**Group Policy No. (s)**	☐ **NEW ENROLLMENT** ☐ **CHANGE IN ENROLLMENT**

PERSONAL DATA: PLEASE FILL OUT ALL INFORMATION AND MAKE SURE IT IS LEGIBLE. *FULL LEGAL NAME - NO NICKNAMES*

Social Security No.	Last Name	First Name	Initial

Male ☐ Female ☐	Date of Birth	Street Address	City	State	Zip Code

Cell Phone	E-Mail Address

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Dependent Children ☐ No ☐ Yes If Yes, #

BENEFICIARY - PRIMARY

Name ______________________ Percentage ______________________

Social Security Number ______________________ Relationship ______________________

Address ______________________ Date of Birth ______________________

City ______________________ Phone Number ______________________

State ____________ Zip ____________

BENEFICIARY - SECONDARY

Name ______________________ Percentage ______________________

Social Security Number ______________________ Relationship ______________________

Address ______________________ Date of Birth ______________________

City ______________________ Phone Number ______________________

State ____________ Zip ____________

Please complete and return this form to Sheet Metal Workers Local 17, 1157 Adams Street, Dorchester, MA 02124.

According to the contract, if there is no beneficiary listed, the proceeds upon death will be paid out as follows:

1. **Spouse**
2. **No Spouse, then Child (ren)**
3. **Neither of the above, The Parents**
4. **None of the Above, Brothers and Sisters**

If there is no family member or surviving family member, then the benefit would be paid to the insured person's estate.

I hereby certify that all information furnished is true to the best of my knowledge. If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contributions in advance from ages due me, for remittance to American General Life Insurance Company. I designate the beneficiary named on this form to receive the proceeds, if any, payable upon my death. I authorize any insures or employer or any consumer reporting agency acting on its behalf to give to American General Life Insurance Company information about me pertaining to my employment or other insurance coverage.

______________________ Date Signed

______________________ Applicant's Signature