BMWE HEALTH AND WELFARE PLAN FOR OCCUPATIONALLY DISABLED MEMBERS

Administered by Southern Benefit Administrators, Incorporated

Mailing Address:
P.O. Box 1449
Goodlettsville, TN 37070-1449

Telephone: (615) 859-0131
Toll Free: (800) 831-4914
Fax: (615) 859-0324

Street Address:
2001 Caldwell Drive
Goodlettsville, TN 37072-2328

ENROLLMENT FORM

In order to enroll for benefits under the Fund, you must complete this form fully and accurately. Incomplete or incorrect information may jeopardize your eligibility for benefits:

INFORMATION ABOUT YOU

Member Name: _____ Social Security No.:_____

Address:_____Phone No.:_____

City: _____ State: _____ Zip: _____

Employee ID No.: _____ Date of Birth: _____

INFORMATION ABOUT YOUR DEPENDENTS THAT YOU WISH TO ENROLL

Spouse's Name: _____ Social Security No.: _____

Date of Birth:_____

Dependent Children's Names:	Date of Birth	Check If Full-time Student	Social Security Number:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

COMPLETE ONLY IF YOU HAVE OTHER INSURANCE

Name of Covered Individual: _____ Social Security No.:_____

Covered Individual's Employer: _____

Name of Insurance Company: _____

I.D. No.:_____ Group No.: _____ Policy No.: _____

I hereby certify that the above information is true and complete. I agree to inform the Trustees of the Fund if I or any of my covered dependents, if applicable, become covered under, or eligible to enroll under, Medicare or any other government-sponsored, railroad-sponsored, employer-sponsored or other group health care plan. I further agree to notify the Trustees of any change in my condition which would cause me to cease to qualify as "occupationally disabled," or should I become divorced from my spouse, if applicable. I further acknowledge that failure to provide any such information on a timely basis may result in my termination of eligibility under the Fund and/or the reimbursement of any claims improperly paid as a result of my failure to provide the required information.

Member Signature: _____ Date: _____

COMPLETE AND MAIL TO:

BMWE Health and Welfare Plan for Occupationally Disabled Members
P.O. Box 1449
Goodlettsville, TN 37070-1449

Call (615) 859-0131 or (800) 831-4914 for assistance.

REMINDER REGARDING THE AVAILABILITY OF MEDICAL COVERAGE FOR OCCUPATIONALLY DISABLED MEMBERS

This will serve as a reminder of the availability of medical coverage for occupationally disabled members under the BMWE Health and Welfare Plan for Occupationally Disabled Members. You may have received previous mailings from the trustees of the plan explaining that the plan was established in order to provide medical coverage to occupationally disabled members of certain participating federations, including this one. This medical coverage is available during the transition period between the time coverage terminates under the National Health and Welfare Plan and the date you become eligible for Medicare or recover from your disability. In order to be covered under the plan, you must meet the plan's eligibility requirements.

The next entry date for the plan is January 1, 2010. If you think you may qualify as of that date, you should begin steps to make application for coverage through the plan office. A more complete explanation of the coverage and of the plan's eligibility rules is available at the office of the plan at:

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A form is available through the plan office if you think you may qualify for benefits as of January 1, 2010. That form must be completed and mailed back to the trustees of the plan by October 31st, so you should contact the plan office as soon as possible to insure that your application is filed on time. If your application is not filed timely, you may be required to wait another year before applying for this coverage.