SHEET METAL WORKERS'
LOCAL UNION NO. 28 FUNDS AND PLANS
METROPOLITAN NEW YORK AND LONG ISLAND

May 4, 2022

Dear Member,

The Local 28 funds office has noticed that either you do not have any beneficiaries on file, or it has been sometime since your beneficiaries have been updated. Included are beneficiary forms for you to fill out, sign, date and return to the Funds office at the address below. We have also enclosed a Coordination of Benefits form that must be filled out, signed, dated, and returned.

You can also find the forms on the Union's website www.smart28.org and clicking on the Union Fusion Portal.

Sincerely,

The Board of Trustees
Sheet Metal Workers Local Union 28

195 MINEOLA BOULEVARD • MINEOLA, NEW YORK 11501
TEL: (516) 742-9478 • FAX: (516) 742-6360

SHEET METAL WORKERS LOCAL UNION 28

BUILDING TRADES / PRODUCTION WORKERS ***(Circle One)***

195 Mineola Blvd, Mineola NY 11501

(516) 742-9478

I)	***MEMBER'S INFORMATION***	
SOCIAL SECURITY NUMBER:		I.A. NO:
LAST NAME	FIRST NAME:	MIDDLE NAME:
DATE OF BIRTH:	SEX: _____	(M) Male (F) Female
ADDRESS		APT NO.:
CITY	STATE:	ZIP CODE:
PRIMARY PHONE: ( ) -	EMAIL ADDRESS	
EMPLOYER'S NAME		DATE OF HIRE:
MARITAL STATUS_____(M) Married, (S) Single, (D) Divorced, (L) Legally Separated		

II)	***DEATH BENEFIT BENEFICIARIES***	
(YOU MAY ATTACH A SEPARATE PAGE IF MORE THAN TWO BENEFICIARIES NEED TO BE LISTED)		
1. BENEFICIARY'S LAST NAME:	BENEFICIARY'S FIRST NAME:	
BENEFICIARY'S FULL SSN:	RELATIONSHIP:	
BENEFICIARY'S DATE OF BIRTH	(P) Primary - (S) Secondary _____	Percentage: _____
BENEFICIARY'S ADDRESS:		
CITY:	STATE:	ZIP CODE:
2. BENEFICIARY'S LAST NAME:	BENEFICIARY'S FIRST NAME:	
BENEFICIARY'S FULL SSN:	RELATIONSHIP:	
BENEFICIARY'S DATE OF BIRTH	(P) Primary - (S) Secondary _____	Percentage: _____
BENEFICIARY'S ADDRESS:		
CITY:	STATE:	ZIP CODE:

III) ***MEDICAL BENEFITS: DEPENDENT COVERAGE***

LIST YOUR DEPENDENTS (Spouse; Children up to age 26)

LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH			SEX		RELATIONSHIP
			MONTH	DATE	YEAR	MALE	FEMALE	(SPOUSE, SON, OR DAUGHTER)

*******Note: Dependent(s) will not be added to your coverage until a marriage or birth certificate is submitted to our office*******

D) SIGNATURE: _____ ***DATE:*** _____

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SMW Welfare Fund Coordination of Benefits Form

In order to update our files and prevent delays in the processing of your claims, we are requesting that the below questionnaire be completed and returned to the Fund Office at the address at the bottom of this form within the next 30 days.

MEMBER'S NAME: _____

MEMBER'S DATE OF BIRTH: _____ MEMBER'S IA#: _____

DEPENDENT(S) NAME/RELATIONSHIP (REL)/DATE OF BIRTH: (LIST ALL)

NAME: _____ REL: _____ DOB: _____

NAME: _____ REL: _____ DOB: _____

NAME: _____ REL: _____ DOB: _____

NAME: _____ REL: _____ DOB: _____

Is your spouse employed? (Circle One): YES NO

If yes, name/address of employer: _____

Is your spouse covered under any employer-sponsored health plan? YES NO

If yes, name/address of carrier: _____

Type of Coverage (Circle all that apply): Medical Dental Vision RX

Does the Plan cover your dependent child(ren)? _____

Effective date of Coverage: _____

Member Signature: _____ Date: _____

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