TEAMSTERS MANAGED ANNUITY PLAN

P.O. BOX 757, PLEASANTON, CA 94566

(800) 924-1226

ENROLLMENT APPLICATION

SECTION A: PARTICIPANT INFORMATION

Social Security Number – –	Employee Last Name	First	Middle Initial	Date of Birth
Home Address/Street	City	State		Zip
Home Phone Number	Cell Phone Number	Email Address		
Employer	Union Local			

SECTION B: ALTERNATIVE MEDICAL COVERAGE

Name of Insurance Company			
Address/Street	City	State	Zip
Phone Number	Plan or Policy Number	Type of Coverage	

Please check appropriate box to the right indicating the other source of insurance coverage:	Parent	Spouse	Secondary Employment	Other*
*If checking "Other" please list source here:				

SECTION C: ACKNOWLEDGEMENT OF ELIGIBILITY

TO QUALIFY FOR THE ANNUITY PLAN YOU MUST PROVIDE PROOF OF VALID ALTERNATIVE MEDICAL COVERAGE (i.e. A COPY OF YOUR IDENTIFICATION CARD OR CONFIRMATION LETTER FROM INSURANCE PROVIDER).

PLEASE NOTE: YOU ARE NOT ELIGIBLE TO ENROLL IN THE ANNUITY PLAN IF YOUR ALTERNATIVE MEDICAL COVERAGE IS PROVIDED BY COVERED CALIFORNIA (EXCHANGE), MEDI-CAL OR MEDICARE.

I have read the above and acknowledge that my alternative medical coverage is NOT provided by Covered California, Medi-Cal or Medicare AND I have attached proof of my alternative medical coverage.

Date	Signature

SECTION D: ELECTION

Under the provisions of the Teamsters Managed Trust Fund, I have elected to participate in the Teamsters Managed Annuity Plan. I understand that this election can only be changed during the open enrollment period as defined by the Board of Trustees. I certify that I currently have alternate medical coverage as stated in Section B of this form.	
Date	Signature
I, the spouse of the plan participant, consent to the above election. I understand that neither I nor our dependent children will be entitled to medical benefits and that this election may not be changed until the open enrollment period, or in the case of a qualifying event, as defined by the Board of Trustees.	
Date	Signature

SECTION E: DESIGNATION OF BENEFICIARY

Subject to the provisions of the Plan, I request that any sum standing to my credit in my account through my participation in the Plan, which sum becomes payable by reason of my death, be paid to the following primary beneficiary:			
Name of Primary Beneficiary			
Relationship to You		Social Security #	
Email Address		Phone #	
Home Address/Street	City	State	Zip

SECTION F: DESIGNATION OF SECONDARY BENEFICIARY

If the above named Primary Beneficiary is not living when payment of my account is to be made from the Plan, I request that payment be made to the following Contingent Beneficiary:		
Name of Contingent Beneficiary		
Relationship to You		Social Security #
I hereby certify that the foregoing information is correct, and I understand that any misstatement of fact or any subsequent change in my marital status may cause this designation of beneficiary to be ineffective. I understand that I can change my designation of beneficiary at any time by filing a new designation of beneficiary form.		
Date	Name	Signature

SECTION G: SPOUSAL CONSENT

Disclosure of requirement for spousal consent: If you are married at the date of your death and you have any individual other than, or in addition to, your surviving spouse as your primary beneficiary under the plan, your spouse must sign (or have signed) a spousal consent and his/her signature must be (or have been) witnessed by a notary public below. If your surviving spouse has not, or does not, consent to the payment of your death benefits to another beneficiary, under the law, he/she will automatically be paid your death benefits.

I, _____ being the Spouse of the Plan Participant whose signature appears above hereby consent to the designation made by my spouse to have his/her "Individual Account" under the Plan, which becomes payable by reason of his/her death, paid to the named beneficiary(ies) specified in this designation of beneficiary form. I hereby acknowledge that I understand (1) that the effect of such designations is to cause my spouse's account to be paid to a beneficiary other than me; (2) that each beneficiary designation is not valid unless I consent to it; and (3) that my consent is irrevocable unless my spouse revokes the beneficiary designation.

Date_____ Name_____

Signature_____

State of _____

County of _____

Signed before me, this _____ day of _____, 20_____