

MC DATE \_\_\_\_\_

for office use only

# LINECO FAMILY ENROLLMENT CARD

Complete and return to:  
LINECO  
Line Construction Benefit Fund  
2000 Springer Drive  
Lombard, IL 60148-7019  
1-800-323-7268

Please **do not** use abbreviations



Employee Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Employee Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
(Street #) (City) (State) (Zip Code)

Date of Birth \_\_\_\_\_ Sex: M or F (Circle One) Cell Phone # (\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

Marital Status: Single Married Divorced Separated Legally Separated Widowed (Circle One)

Spouse Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

\*\*\*\*\* Attach a CERTIFIED copy of the marriage certificate \*\*\*\*\*

Spouse employer name, address & phone number: If not employed, please indicate not employed: \_\_\_\_\_

Dependent child / dependent child's spouse's employer name, address & phone # \_\_\_\_\_

Does the employee or listed dependent(s) have medical, dental, drug coverage with anyone **other** than Lineco? **YES NO**  
(Circle One)

If yes, provide the name, address, phone number and copy of ID card(s) of all coverages

### LIST ALL DEPENDENT CHILDREN UNDER AGE 26

Full Legal Name	Sex	Child's Relationship to you (natural child, stepchild, or other, please specify)	Social Security #	Birthdate	Employed Yes or No
1. _____					
2. _____					
3. _____					
4. _____					

FOR ANY CHILD LISTED ABOVE NOT BORN OF YOUR CURRENT MARRIAGE, SEE REVERSE SIDE.  
SUBMIT COPIES OF THE DIVORCE DECREE OR COPIES OF ALL COURT DOCUMENTS RELATING TO THAT CHILD.  
ANY MISSING INFORMATION WILL DELAY THE PROCESSING OF CLAIMS.

\*\*\*\*\*CALL THE FUND OFFICE FOR ALL ADDRESS AND PHONE NUMBER CHANGES\*\*\*\*\*

**COMPLETE LIFE INSURANCE INFORMATION ON THE REVERSE SIDE**

Date Signed

Signature of Employee

**PROVIDE NATURAL PARENTS' INFORMATION FOR EACH CHILD. INFORMATION SHOULD INCLUDE PARENT'S NAME, ADDRESS, PHONE NUMBER, BIRTHDATE, SOCIAL SECURITY NUMBER OR ID NUMBER, EMPLOYER NAME, ADDRESS, PHONE NUMBER, AND ALL INSURANCE INFORMATION WITH A COPY OF THE MEDICAL/DENTAL CARD(S). PROVIDE THE SAME INFORMATION FOR ALL STEP-PARENTS.**

Child's Name \_\_\_\_\_ Relationship to Lineco Employee \_\_\_\_\_

Natural **Mother's** Name \_\_\_\_\_ Phone # ( \_\_\_\_\_ )  
(if not Lineco Employee)

Address \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security/ID # \_\_\_\_\_

Employer Name \_\_\_\_\_

Address and Phone Number \_\_\_\_\_

Insurance Name \_\_\_\_\_

Address and Phone Number \_\_\_\_\_

Natural **Father's** Name \_\_\_\_\_ Phone # ( \_\_\_\_\_ )  
(If not Lineco Employee)

Address \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security/ID # \_\_\_\_\_

Employer Name \_\_\_\_\_

Address \_\_\_\_\_ Phone # ( \_\_\_\_\_ )

Insurance Name \_\_\_\_\_

Address \_\_\_\_\_ Phone # ( \_\_\_\_\_ )

Who has physical custody of child? \_\_\_\_\_

**\*\*\*\*\*LIFE INSURANCE BENEFICIARY INFORMATION\*\*\*\*\***

Employee Name \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Name of Beneficiary

Last	First	Middle Initial	Date of Birth	Relationship

Beneficiary Address \_\_\_\_\_ Phone # ( \_\_\_\_\_ )

The above named beneficiary supercedes any and all beneficiaries previously designated. (Designation of a beneficiary will be valid only if the Fund Office receives this form while you (the employee) are still living.)

\_\_\_\_\_ **Date Signed**

\_\_\_\_\_ **Signature of Employee**