

BMW 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
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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:

BMW 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.