LABOR ASSOCIATION OF WISCONSIN
HEALTH BENEFIT TRUST
Enrollment Form

(Please Print)

Name:	
Street Address: **City:** **State:** **Zip Code:**	
E-mail Address:	
Social Security Number:	
Phone Number:	**Cell Phone Number:**
Date of Birth:	
Date of Hire:	
LAW Local Name:	
Beneficiary:	**Relationship:**
Beneficiary Address:	**Beneficiary Date of Birth:**

By signing below, I hereby elect to contribute $10 per month to the Labor Association of Wisconsin Insurance Trust (the "Trust"), commencing as of the effective date noted above. I understand the following:

- **My monthly contribution is due as of the first day of each month.**
- I understand I can pay the required contribution in larger increments (for example, $120 per year, rather than $10 per month, provided the contribution must still be paid in advance of the period to which it relates).
- I hereby agree to be subject to, and shall comply with, the terms of the Trust and the related Plan document.
- I understand my contribution is not tax deductible.
- I understand I am eligible to receive benefits in accordance with the terms of the Plan and Trust.
- I understand that when I am eligible to receive a benefit from the Trust, it will be to help offset insurance premium costs for health, dental or vision insurance, at my option, and direction consistent with the guidelines of the Plan and Trust.
- I understand I will not be eligible to receive benefits from the Plan and Trust or receive a refund of my contributions if I cease to be a member of the Labor Association of Wisconsin, Inc.
- I understand I must maintain status as either a full service member or an affiliate member, to be eligible for any benefits from the Trust.

Based on the foregoing, I hereby elect to enroll in the Trust effective as of the date received by the Trust Administrator.

_____

Signature Local Name/Number

_____ Full Service member ☐ Affiliate Member ☐

Date

Received by the Plan Administrator on the _____ day of_____, 20___.

_____

Benjamin M. Barth, President
Labor Association of Wisconsin, Inc.

Effective Date: _____

Return completed form to:

Labor Association of Wisconsin, Inc.
VEBA Health Trust
N116 W16033 Main Street
Germantown, WI 53022