

# JATC ENROLLMENT FORM

Contact Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Local Name and #: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
E-mail : \_\_\_\_\_

Mail to: Mass Benefits Consultants, Inc.  
P.O. Box 828  
Annandale, VA 22003-0828

PHONE: 1-800-221-3083

We wish to participate in the Joint Apprenticeship & Training Committee Accident Insurance Plan(s) as selected below. All participant numbers to be determined as of Enrollment date. Each category is optional, but must include all eligibles in each category.

Apprentices \_\_\_\_\_

Upgrading Journeyman \_\_\_\_\_

J.A.T.C members  
(T.D. included) \_\_\_\_\_

Instructors \_\_\_\_\_

TOTAL: \_\_\_\_\_

**\$25,000 Medical Maximum and \$400 Weekly Accident Indemnity:**

PRIMARY Cost is \$26.40 or EXCESS Cost is \$24.20 per participant TOTAL \$ \_\_\_\_\_

**\$25,000 Medical Maximum and \$200 Weekly Accident Indemnity:**

PRIMARY Cost is \$15.40 or EXCESS Cost is \$13.20 per participant TOTAL \$ \_\_\_\_\_

**\$25,000 Medical Maximum and NO Weekly Accident Indemnity:**

PRIMARY Cost is \$9.90 or EXCESS Cost is \$7.70 per participant TOTAL \$ \_\_\_\_\_

**By signing this form, we agree to participate in the Mass Benefits Consultants Trust Policy and to be bound by each and every provision of the Master Policy (and all riders and amendments thereto).**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME AND TITLE

(CLAIM FORMS AVAILABLE AS REQUIRED FROM MASS BENEFITS)