

# ENROLLMENT FORM

(to be completed by the participating Local)

Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Local Name and #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

We wish to participate in the Apprenticeship & Training Committee Accident Insurance Plan. Coverage will begin the date the application and payment is received.

Coverage may be purchased for each of the following categories (all eligible participants in each selected category must be covered):

<u>Category</u>	<u>Number of Participants</u>	
Apprentices	_____	
Trainees	_____	
Instructors	_____	
Upgrading Journeymen	_____	
<b>TOTAL:</b>	_____	<b>\$ _____</b>

\$50,000 Medical Maximum and \$200 Weekly Accident Indemnity:  
Cost is \$25.00 per participant      OPTION IC TOTAL \$ \_\_\_\_\_

\$25,000 Medical Maximum and \$200 Weekly Accident Indemnity:  
Cost is \$12.00 per participant      OPTION IB TOTAL \$ \_\_\_\_\_

\$25,000 Medical Maximum and NO Weekly Accident Indemnity:  
Cost is \$ 7.00 per participant      OPTION 1 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)