Labor Alliance Savings Trust Fund

LABOR ALLIANCE SAVINGS PLAN
ENROLLMENT APPLICATION – INSTRUCTIONS

Please read the information below carefully before completing the Labor Alliance Savings Trust ("Savings Plan") Enrollment Application.

Eligibility:

In order to enroll in the Savings Plan, you must provide the Trust Fund with proof of valid***** alternative medical insurance (i.e., coverage through a spouse, secondary employment, veterans affairs or parent).

***Note: Covered California (Exchange), Medi-Cal and Medicare are NOT deemed valid forms of alternative medical insurance.**

Required Documents:

The following documents must be provided to the Plan Administrative Office:

1. Completed Enrollment Application ***(Must be signed)***
2. Notarized Spousal Consent ***(If applicable)***
3. Proof of Valid Alternative Medical Insurance* ***(Must show Plan Participant's name)***
   - For example: A copy of alternative medical insurance ID card issued within the last twelve (12) months (***with an effective and or issued date***), or the most recent Form 1095-B, or a confirmation letter from the alternative medical insurance company.

***Note: Annual Verification Required. Does Not Apply to VA Benefits.**

Designation of Beneficiary and Spousal Consent:

The Enrollment Application includes a Designation of Beneficiary (see "Section D") wherein you can list the individual who is to receive the funds in your savings account in the event of your death. Please note that if you are married at the time of your death and you have an individual other than, or in addition to your surviving spouse as your beneficiary under the Plan, your spouse must sign (or have signed) a "Spousal Consent" (see "Section E") and must be (or have been) witnessed by a Notary Public.

If you have any questions pertaining to the above referenced, please call the Plan Administrative Office at (800) 924-1226. The office hours are from 9:00 a.m. to 4:30 p.m. Monday through Friday.

Post Office Box 757 Pleasanton, CA 94566 (800) 924-1226 Fax: (877) 738-3815

LABOR ALLIANCE SAVINGS TRUST FUND

P.O. BOX 757, PLEASANTON, CA 94566

(800) 924-1226

ENROLLMENT APPLICATION

SECTION A: PARTICIPANT INFORMATION

Social Security Number – –	Employee Last Name	First	Middle Initial	Date of Birth
Home Address/Street	City	State	Zip	
Home Phone Number	Cell Phone Number	Email Address		
Employer	Union Local			

SECTION B: ALTERNATIVE MEDICAL COVERAGE

Name of Insurance Company			
Address/Street	City	State	Zip
Phone Number	Plan or Policy Number	Type of Coverage	

Please check appropriate box to the right indicating the other source of insurance coverage:	Spouse	Parent	Secondary Employment	VA

SECTION C: ELECTION

Under the provisions of the Labor Alliance Managed Trust Fund, I have elected to participate in the Labor Alliance Savings Trust Fund. I understand that this election can only be changed during open enrollment or if there is a qualifying event. I certify that I currently have alternative medical coverage as stated in “Section B" of this form.	
Plan Participant Signature	Date
I, the spouse of the plan participant, consent to the above election. I understand that neither I nor our dependent children will be entitled to medical benefits and that this election may not be changed until the open enrollment period, or in the case of a qualifying event, as defined by the Board of Trustees.	
Spouse Signature	Date

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SECTION D: DESIGNATION OF BENEFICIARY

Subject to the provisions of the Plan, I request that any funds held in my individual account be payable by reason of my death, to the following beneficiary:

Name of Beneficiary			
Relationship		Social Security #	
Email Address		Phone #	
Home Address/Street	City	State	Zip

I hereby certify that the foregoing information is correct and I understand that any misstatement of fact or any subsequent change in my marital status may cause this designation of beneficiary to be ineffective. I understand that I can change my designation of beneficiary at any time by contacting the Plan Administrative Office.

Plan Participant Signature	Date

SECTION E: SPOUSAL CONSENT

<u>Special Disclosure:</u> If you are married at the time of your death and you have any individual other than, or in addition to, your surviving spouse as your beneficiary under the Plan, your spouse must sign (or have signed) a spousal consent and must be (or have been) witnessed by a Notary Public (see below). If your surviving spouse has not, or does not, consent to the payment of your death benefits to another beneficiary, under the law, your spouse will automatically be paid your death benefits.

I, _____ being the spouse of the Plan Participant whose signature appears above hereby consent to the designation made by my spouse to have the "Individual Account" under the Plan, which becomes payable by reason of my spouse's death, paid to the named beneficiary specified in the Designation of Beneficiary section. I hereby acknowledge that I understand (1) that the effect of such designation is to cause my spouse's account to be paid to a beneficiary other than myself; (2) that beneficiary designation is not valid unless I consent; and (3) that my consent is irrevocable unless my spouse revokes the beneficiary designation.

Date_____ Name_____

Signature_____

State of _____

County of _____

Signed before me, this _____ day of _____, 20_____

Place Notary Seal or Stamp Above