BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 2 NY
JOINT BENEFIT FUND
300 Centre Drive
Albany, New York 12203
PARTICIPANT DATA SHEET

This form is specifically for the protection of your benefits and will be your permanent record. Please be sure you fill in all personal information called for on both **Side I and Side II.** Return this completed and signed form to the Fund Office at the above address. **PLEASE PRINT ALL INFORMATION.**

Last Name	First Name	M.I.	Date of Birth

Street Address	City	State	Zip Code

Social Security Number	Area Code and Phone Number	Email Address

Single ( ) Married ( ) Re-married ( ) Divorced ( ) Widowed ( )

Is Member covered under another group medical plan? ( ) Yes ( ) No
If **"YES"** indicate name and address of insurance carrier through which medical coverage is provided.
Name: _____
Address: _____
Effective Date: _____

BENEFICIARY DESIGNATIONS
BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 2 HEALTH BENEFIT

**Primary Beneficiary's Name: _____ Date of Birth: _____
Address & Phone Number: _____
Social Security Number: _____ Relationship: _____

**Secondary Beneficiary's Name: _____ Date of Birth: _____
Address & Phone Number: _____
Social Security Number: _____ Relationship: _____

BRICKLAYERS & ALLIED CRAFTWORKERS LOCAL 2 PENSION FUND
In accordance with Federal Law, if you are a vested Participant "Beneficiary" means your lawful spouse or, if there is no lawful spouse, the person you specify as your Designated Beneficiary under the Health Benefit Fund above.

BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL 2 ANNUITY FUND
Under the Plan "Beneficiary" means your spouse, or if there is no spouse, then the person or persons you have specified in writing as your Designated Beneficiary. Your spouse must consent in writing, witnessed by a notary public, to your designation of a non-spouse Beneficiary in order to have the Death Benefit paid to a Designated Beneficiary.

EMPLOYEE'S CERTIFICATION
I understand that this will cancel out any previous beneficiary designation or designators which I have made. I reserve the right to change my beneficiary or beneficiaries at any future date. I certify that all information provided on this form is true and correct. I understand and agree that any false information may disqualify me for benefits and that the Fund Office shall have the right to recover any benefit payments made because of such false information.

_____ _____
Employee's Signature Date Signed