IBEW/NECA SOUND & COMMUNICATIONS HEALTH & WELFARE TRUST FUND

EMPLOYEE ENROLLMENT CARD

EMPLOYEE'S LAST NAME	FIRST	MIDDLE INITIAL	DATE OF BIRTH MO. DAY YR.	SOCIAL SECURITY NO.	SEX M ☐ F ☐

NUMBER	STREET	CITY	STATE	ZIP CODE	TELEPHONE NUMBER

NAME AND RELATIONSHIP OF BENEFICIARY (OR BENEFICIARIES)

LAST	FIRST	MIDDLE INITIAL	RELATIONSHIP

NAME OF EMPLOYER

LOCAL UNION

☐ SINGLE ☐ WIDOWED
☐ MARRIED ☐ DIVORCED
☐ SEPARATED

DO YOU WISH TO INSURE YOUR HUSBAND / WIFE AND CHILDREN?
☐ YES ☐ NO

DO YOU HAVE OTHER MEDICAL INSURANCE?
☐ YES ☐ NO

DO YOUR DEPENDANTS HAVE OTHER MEDICAL INSURANCE?
☐ YES ☐ NO

NAME OF SPOUSE'S EMPLOYER

LIST ONLY ELIGIBLE FAMILY MEMBERS TO BE ENROLLED

RELATIONSHIP	LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH	SOCIAL SECURITY NUMBER
☐ HUSBAND ☐ WIFE					
☐ SON ☐ DAUGHTER					
☐ SON ☐ DAUGHTER					
☐ SON ☐ DAUGHTER					
☐ SON ☐ DAUGHTER					
☐ SON ☐ DAUGHTER					

DATE SIGNED _____ SIGNATURE OF MEMBER _____ DATE OF EMPLOYMENT _____

Return to United Administrative Service, P.O. Box 5057, San Jose, CA 95150

CLAIMS CANNOT BE PROCESSED UNLESS YOUR ENROLLMENT CARD IS ON FILE