IBEW SOUND & COMMUNICATIONS HEALTH & WELFARE TRUST FUND

EMPLOYEE ENROLLMENT CARD

NAME OF PARTICIPANT (Last, First, MI)	DATE OF BIRTH	SOCIAL SECURITY NO.	☐MALE ☐FEMALE
HOME ADDRESS OF PARTICIPANT (CITY, STATE, ZIP)		TELEPHONE NO. (Include Area Code)	
NAME OF EMPLOYER	LOCAL UNION	☐SINGLE ☐MARRIED	☐WIDOWED ☐DIVORCED ☐SEPARATED
NAME OF BENEFICIARY (Last, First, MI)		RELATIONSHIP	

DO YOU HAVE OTHER MEDICAL INSURANCE	DO YOU WISH TO INSURE YOUR SPOUSE AND CHILDREN?	DO YOUR DEPENDANTS HAVE OTHER MEDICAL INSURANCE?	OTHER MEDICAL INSURANCE:
☐YES ☐NO	☐YES ☐NO	☐YES ☐NO	DEPENDENT'S NAME: ______ NAME OF COMPANY: ______ ADDRESS: ______

DEPENDENT INFORMATION	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP	EMPLOYER

NAME AND ADDRESS OF SPOUSE'S EMPLOYER	**Are any of your dependents over the age of 18 full-time students? ☐YES ☐NO** **NAME OF SCHOOL:** ______ **NAME OF STUDENT:** ______

PARTICIPANT SIGNATURE: ______________________ DATE: ______________________

RETURN TO UNITED ADMINISTRATIVE SERVICES PO BOX 5057, SAN JOSE, CA 95150

YOUR CLAIMS WILL NOT BE PROCESSED UNLESS YOUR ENROLLMENT CARD IS ON FILE (PLEASE PRINT)