ENROLLMENT FORM

IUPAT District Council #51 Health & Welfare Fund

			F: ,			٦.	4: 1 11		0 11		
Last:			First:			IV	fliddle:		Suffix:		
Address 1: Address 2:											
_			Ctata					7in Cod			
City:	Hairan		State:			1	Lasallisia	Zip Cod	e:		
Name of Home Local	Union:				A11 (A1 1		Local Unior	1#:			
Home Phone:					Alternate Number:						
Social Security Number	er:				Sex: Male		☐ Female				
Marital Status: (Check One)	Married 🗆		Single 🗆	Div	rorced \square	Legall	y Separated D]	Widowed □		
OTHER COVERA	GE										
Do you or any of your dependents have additional health coverage?											
If "YES", what type of coverage? ☐ Individual ☐ Group											
Name of the Insured:											
Name of Insurance Ca	arrier:										
Telephone Number fo	r Verification of Be	enefits:									
Policy Number:					Group Number:						
I certify all informatio	n provided true ar	nd correct.									
Participant's Signatu	re			Date)						
DEPENDENT EN	ROLLMENT										
Last:			First:				Middle:		Suffix:		
Social Security Number	er:		-	-							
Date of Birth:	-	-			Sex: Male		☐ Female				
Relationship to Partici (Select One)			Spouse		☐ Biological Chil			☐ Step			
Other: (Please explain)		(submit copy of	marriage certificate)		(submit copy of birth certific	cate)		(submit copy of b	oirth certificate)		
Marital Status: (Check One)	☐ Married		☐ Single								
Does this dependent r	eside outside vou	r household?		☐ YES	□ NO						
If yes, please indicate											
Last:			First:				Middle:		Suffix:		
Social Security Number	er:		-	-							
Date of Birth:	-	-			Sex: Male		☐ Female				
Relationship to Partici (Select One)			Spouse marriage certificate)		☐ Biological Chil			☐ Step			
Other: (Please explain)		(Submit copy of	mamaye certificate)		(admin copy of bitti certilio	oale)		(Submit copy of t	on an Cerumoale)		
Marital Status: (Check One)	☐ Married	I	☐ Single								
Does this dependent r	eside outside you	r household?		☐ YES	□ NO						

Last: First:	Middle:	Suffix:									
Social Security Number:											
Date of Birth: Sex: Male	☐ Female										
Relationship to Participant: (Select One) Spouse (submit copy of marriage certificate) Biological Child (submit copy of birth certificate)		Step-child (submit copy of birth certificate)									
Other: (Please explain)		(cushin copy or biral continuato)									
Marital Status: (Check One) Married ☐ Single ☐											
Does this dependent reside outside your household?											
If yes, please indicate the address:											
Last: First:	Middle:	Suffix:									
Social Security Number:											
Date of Birth: Sex: Male	☐ Female										
Relationship to Participant: (Select One) Spouse (submit copy of marriage certificate) Biological Child (submit copy of birth certificate)		☐ Step-child (submit copy of birth certificate)									
Other: (Please explain)											
Marrial Status: (Check One) Married ☐ Single ☐											
Does this dependent reside outside your household? ☐ YES ☐ NO											
If yes, please indicate the address:											
Last: First:	Middle:	Suffix:									
Social Security Number:											
Date of Birth: Sex: Male	☐ Female										
Relationship to Participant: (Select One) Spouse (submit copy of marriage certificate) Biological Child (submit copy of birth certificate)		☐ Step-child (submit copy of birth certificate)									
Other: (Please explain)											
Marital Status: Married ☐ Single ☐											
Does this dependent reside outside your household? ☐ YES ☐ NO											
If yes, please indicate the address:											
Last: First:	Middle:	Suffix:									
Social Security Number:											
Date of Birth: Sex: Male	☐ Female										
Relationship to Participant: (Select One) Spouse (submit copy of marriage certificate) Biological Child (submit copy of birth certificate)		☐ Step-child (submit copy of birth certificate)									
Other: (Please explain)											
Marital Status: (Check One) Married ☐ Single ☐											
Does this dependent reside outside your household? ☐ YES ☐ NO											
If yes, please indicate the address:											