


<b>ELECTRICAL WORKERS LOCAL 332 HEALTH AND WELFARE TRUST</b>		<b>ENROLLMENT CARD</b> YOUR CLAIMS WILL NOT BE PROCESSED UNLESS YOUR ENROLLMENT CARD IS ON FILE (Please Print)		 <b>UNITED ADMINISTRATIVE SERVICES</b>	
NAME OF PARTICIPANT (Last, First, MI)		DATE OF BIRTH	SOCIAL SECURITY NO.	EMPLOYER NAME	
HOME ADDRESS OF PARTICIPANT (City, State, Zip)				TELEPHONE NO. (include Area Code)	
<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	DO YOU HAVE OTHER MEDICAL INSURANCE?  <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOUR DEPENDENTS HAVE OTHER MEDICAL INSURANCE?  <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER MEDICAL INSURANCE:	
<input type="checkbox"/> SINGLE	<input type="checkbox"/> WIDOWED			DEPENDENT'S NAME: _____	
<input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED SEPARATED			NAME OF COMPANY: _____	
MARRIAGE DATE (If applicable): _____			DIVORCE DATE (If applicable): _____		
<b>DEPENDENT INFORMATION</b>		DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP	EMPLOYER
NAME AND ADDRESS OF SPOUSE'S EMPLOYER		Are any of your dependents over age 18 full-time students?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
_____		Name of School: _____		Name of Student: _____	
PARTICIPANT SIGNATURE: _____			DATE: _____		
-----FOLD ON THIS LINE AND RETURN-----					



Fax or email completed form to Lynda Rodarte at United Administrative Services. Fax: (408) 288-4439 Email: [Irodarte@uastpa.com](mailto:Irodarte@uastpa.com)