ELECTRICAL WORKERS LOCAL 332 HEALTH AND WELFARE TRUST	**ENROLLMENT CARD** YOUR CLAIMS WILL NOT BE PROCESSED UNLESS YOUR ENROLLMENT CARD IS ON FILE (PLEASE PRINT)	United Administrative Services

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)

☐MALE ☐FEMALE ☐SINGLE ☐WIDOWED ☐MARRIED ☐DIVORCED SEPARATED	DO YOU HAVE OTHER MEDICAL INSURANCE ☐YES ☐NO	DO YOUR DEPENDANS HAVE OTHER MEDICAL INSURANCE? ☐YES ☐NO	OTHER MEDICAL INSURANCE: DEPENDENT'S NAME: _____ NAME OF COMPANY: _____ ADDRESS: _____

MARRIAGE DATE (if applicable)	DIVORCE DATE (If applicable)

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: _____