


<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)		 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)		
<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	DO YOU HAVE OTHER MEDICAL INSURANCE	DO YOUR DEPENDANS HAVE OTHER MEDICAL INSURANCE?	OTHER MEDICAL INSURANCE:	
<input type="checkbox"/> SINGLE	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DEPENDENT'S NAME: _____	
<input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED SEPARATED		<input type="checkbox"/> YES	<input type="checkbox"/> NO	NAME OF COMPANY: _____
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? <input type="checkbox"/> YES <input type="checkbox"/> NO			
		NAME OF SCHOOL: _____		NAME OF STUDENT: _____	
PARTICIPANT SIGNATURE: _____			DATE: _____		