ENROLLMENT CARD

UFCW Local 152 Health & Welfare Fund • 27 Roland Ave, Suite 100 • Mt. Laurel, NJ 08054

NAME (LAST) (FIRST) (MIDDLE) (SUFFIX) | Social Security #

Phone #

ADDRESS (STREET) APT # (CITY) (STATE) (ZIP) | DATE OF BIRTH / /

FOR FUND USE ONLY	NAME OF EMPLOYER	LOCAL UNION #	SEX
EMP. #			___Male ___Female
PLAN:	DATE OF HIRE / /	(Circle one) Full Time or Part Time	
EFFECTIVE DATE:			

Type of Application

☐ New Participant ☐ Add Dependent(s)

☐ Reinstated - Date Returned to Work _____

☐ Change in Benefits ☐ Change of Address

Name of Spouse (First & Last Name)	Spouse's Birth Date / /
Primary Beneficiary (First & Last Name)	Address & SSN # / Relationship
Contingent Beneficiary (First & Last Name)	Address & SSN # / Relationship

Marital Status:
☐ Married ☐ Single
☐ Divorced ☐ Separated
☐ Widowed
Date of above event: _____

Number Eligible Dependent Children: _____

SIGN HERE ➡ _____

Date Signed _____

(please complete back of card)

Print the name of each dependent below. Dependents include your eligible spouse and eligible children under 26 years of age only. All eligible dependents must be listed and an Adult Enrollment Form is required to be completed for dependents over age 19. Please return all required documents with this card (marriage certificates, birth certificates, etc.)

LIST FIRST, LAST & MIDDLE NAME OF EACH ELIGIBLE DEPENDENT BELOW (DO NOT REPEAT YOUR OWN NAME)	SOCIAL SECURITY #	BIRTH DATE			RELATIONSHIP			
		MO.	DAY	YEAR	SPOUSE	SON	DAUGHTER	OTHER

DOES YOUR SPOUSE HAVE OTHER INSURANCE? ☐ YES ☐ NO IF YES, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW.

SPOUSE NAME:	SS#:
EMPLOYER NAME:	PHONE #
EMPLOYER ADDRESS:	
INSURANCE CARRIER:	PHONE #
EFFECTIVE DATE OF POLICY:	