



Participant Information									
Name:			SSN:			Date of Birth:			
Address:									
City:			State:			Zip:			
Cell Phone:			Email Address:						
Would you like electronic copies of plan documents?					Yes		No		
Marital Status:		Single	Married		Divorced	Separated		Widowed	
Are you Medicare Eligible?		Yes	No	If Yes, do you have		Part A	Part B	Part D	
Are you covered by any other plan that would be primary?					Yes			No	
<i>If Yes, is the coverage (check one)</i>					Family			Single	
<i>If Yes, is the policy (check all that apply)</i>					Medical	Prescription	Dental	Vision	
Name of Insurance					Effective Date				
Medical:									
Prescription:									
Dental:									
Vision:									
Spouse Information									
Name:			SSN:			Date of Birth:			
Address:									
City:			State:			Zip:			
Cell Phone:			Email Address:						
Are you Medicare Eligible?		Yes	No	If Yes, do you have		Part A	Part B	Part D	
Are you covered by any other plan that would be primary?					Yes			No	
<i>If Yes, is the coverage (check one)</i>					Family			Single	
<i>If Yes, is the policy (check all that apply)</i>					Medical	Prescription	Dental	Vision	
Name of Insurance					Effective Date				
Medical:									
Prescription:									
Dental:									
Vision:									
Dependent Information									
Name:			SSN:			Date of Birth:			
Name:			SSN:			Date of Birth:			
Name:			SSN:			Date of Birth:			
Name:			SSN:			Date of Birth:			
Name:			SSN:			Date of Birth:			
Are any of these dependents covered under another insurance plan? <i>(other than what is listed above in the Spouse Section)</i>					Yes			No	
<i>If Yes, is the policy (circle all that apply)</i>					Medical	Prescription	Dental	Vision	
Name of Insurance					Effective Date		Policyholder's Name		
Medical:									
Prescription:									
Dental:									
Vision:									

PLEASE READ CAREFULLY AND SIGN BELOW I hereby certify that the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentionally falsify or fail to give any of the information on this form, claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of the change.

Signature of Participant:					Date:				
Signature of Spouse:					Date:				