SIDE I
(PLEASE COMPLETE SIDE 2)
(Please Print)

U.A. LOCAL 467 HEALTH & WELFARE TRUST FUND
MEMBER ENROLLMENT CARD

☐ NEW
☐ CHANGE
☐ ADD

MEMBER'S LAST NAME	FIRST	INITIAL	LOCAL NUMBER	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX

MEMBER'S ADDRESS	MEMBER'S PHONE NUMBER	DATE OF EMPLOYMENT
		MONTH DAY YEAR

NAME OF PRESENT EMPLOYER

**** DEPENDENT INFORMATION **** Please note: the below area must be completed if applying for Dependent Coverage.

NAME (Last, First, MI)	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP	EMPLOYER or NAME OF SCHOOL *Please provide name of school if any dependents are full-time students

Name, address & policy # of spouse's health carrier(s):

SIDE 2

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*** BENEFICIARY INFORMATION *** Please note: the area below must be completed.

Please complete an attached list if you want to name more persons than provided for on this form.

NAME OF BENEFICIARY	LAST	FIRST	MIDDLE	DATE OF BIRTH	RELATIONSHIP TO MEMBER

FULL ADDRESS OF BENEFICIARY

If the beneficiary dies before me, I designate as contingent beneficiary:

NAME OF CONTINGENT BENEFICIARY	LAST	FIRST	MIDDLE	DATE OF BIRTH	RELATIONSHIP TO MEMBER

FULL ADDRESS OF CONTINGENT BENEFICIARY

I request to be insured for benefits and certify that the above dependents are eligible for benefits under the Group Policy or Policies applicable for the U.A. Local 467 Trust Fund.

DATE SIGNED _____ SIGNATURE OF MEMBER _____

Return to U.A. Local #467, 1519 Rollins Rd., Burlingame, CA 94010

CLAIMS CANNOT BE PROCESSED UNLESS YOUR ENROLLMENT CARD IS ON FILE