Warehouse Employees Union Local No. 730
Health and Welfare Trust Fund

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Sparks, Maryland 21152-9451
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www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
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ENROLLMENT FORM

Name of Employee

Last Name	First Name	MI	OFFICE USE ONLY Effective	Terminated
Address		Local Union No.	A.	
			B.	
City	State	Zip Code	C.	

Telephone	Sex: M/F	Date Employed	Date of Birth
Your Social Security No.		Company, Job Classification	

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Date of Marriage:

Coverage Desired: ☐ Individual ☐ Parent/Child ☐ Husband/Wife ☐ Family

Name of any other health insurance covering you, including Medicare

Name of Insured: _____ Type of Insurance: _____

Policy No.: Name of Insurance:

Death Benefits to be paid to (Name/Relationship):

Beneficiary's Address:

Date Signed Signature

PLEASE READ BOTH SIDES OF THIS FORM CAREFULLY.

LIST BELOW NAME(S) OF YOUR SPOUSE AND CHILDREN UNDER AGE 26
FOR WHOM YOU DESIRE COVERAGE

LIST NAME IN ORDER OF AGE - ELDEST FIRST	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NO. * **REQUIRED**

A COPY OF YOUR MARRIAGE LICENSE AND/OR DEPENDENT'S BIRTH CERTIFICATE MUST BE INCLUDED WITH THIS APPLICATION
***SOCIAL SECURITY NUMBERS ARE REQUIRED FOR ANY ELIGIBLE DEPENDENTS IN ORDER TO RECEIVE BENEFITS**

Name any other health insurance covering your dependent(s), including Medicare:

Name: _____ **Policy No.:** _____

Name: _____ **Policy No.:** _____

I certify that I have carefully read both sides of the enrollment form and agree to the terms specified thereon. The foregoing statements are complete, true & correctly recorded.

I hereby apply for participation for my dependent(s) in the Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund. I understand that I, the participant must be enrolled as well, and that this application is subject to me being employed by a Participating Employer and covered by a collective bargaining agreement with a Participating Union. I and my dependent(s) agree to follow the rules and regulations determined by the Board of Trustees as communicated to me through the Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund Summary Plan Description or updates thereto.

Participant Signature (DO NOT PRINT): _____ **Date:** _____