

**IBEW/NECA SOUND & COMMUNICATIONS HEALTH & WELFARE TRUST FUND  
EMPLOYEE ENROLLMENT CARD**

EMPLOYEE'S LAST NAME		FIRST	MIDDLE INITIAL	DATE OF BIRTH MO. DAY YR.		SOCIAL SECURITY NO.	SEX M <input type="checkbox"/> F <input type="checkbox"/>
NUMBER	STREET	CITY	STATE	ZIP CODE	TELEPHONE NUMBER		

NAME AND RELATIONSHIP OF BENEFICIARY (OR BENEFICIARIES)

LAST FIRST MIDDLE INITIAL RELATIONSHIP

NAME OF EMPLOYER

LOCAL UNION

SINGLE     WIDOWED  
 MARRIED     DIVORCED  
 SEPARATED

DO YOU WISH TO INSURE YOUR HUSBAND / WIFE AND CHILDREN?  
 YES     NO

DO YOU HAVE OTHER MEDICAL INSURANCE?  
 YES     NO

DO YOUR DEPENDANTS HAVE OTHER MEDICAL INSURANCE?  
 YES     NO

NAME OF SPOUSE'S EMPLOYER

**LIST ONLY ELIGIBLE FAMILY MEMBERS TO BE ENROLLED**

RELATIONSHIP	LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH	SOCIAL SECURITY NUMBER
<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE					
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER					
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER					
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER					
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER					
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER					

DATE SIGNED \_\_\_\_\_

SIGNATURE OF MEMBER \_\_\_\_\_

DATE OF EMPLOYMENT \_\_\_\_\_

Return to United Administrative Service, P.O. Box 5057, San Jose, CA 95150  
**CLAIMS CANNOT BE PROCESSED UNLESS YOUR ENROLLMENT CARD IS ON FILE**