PLEASE SUBMIT A COPY OF YOUR MARRIAGE CERTIFICATE AND/OR BIRTH CERTIFICATES FOR YOUR CHILDREN WITH THIS CARD.

RETURN TO: IAM DISTRICT NO. 15 HEALTH FUND
140 Sylvan Avenue – Suite 303
Englewood Cliffs, NJ 07632
201-947-8000 FAX 201-947-9192

ENROLLMENT CARD

Please Print (except for signature)

NAME			SEX		SOCIAL SECURITY NO.
Last	First	Init.	M	F	

ADDRESS			
Number and Street	City	State	Zip

BIRTH DATE			HOME PHONE		UNION	
Month	Day	Year	Area Code	Number	Local No.	Initiation Date

MARITAL STATUS (Check One)
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow(er)

DATE OF MARRIAGE

PRESENT EMPLOYER

HIRE DATE

Beneficiary* Name _____

Relationship to Insured _____ Birth Date of Beneficiary _____

Address of Beneficiary _____

• LIST YOUR SPOUSE AND ELIGIBLE DEPENDENTS BELOW (refer to your Employee Booklet for definitions of Eligible Dependents).
• DO YOU OR ANY OF YOUR DEPENDENTS HAVE ADDITIONAL HEALTH INSURANCE? Yes ☐ No ☐. If Yes Give Details on Reverse Side.

FIRST NAME	INIT.	LAST NAME (if different)	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER
			SPOUSE		
OTHER DEPENDENTS					

I certify all information on this form is true and correct. *I understand that my beneficiary designation will apply to any and all Funds for which I have not specifically requested, completed and filed a separate beneficiary form. The information on this card supersedes all previous information cards.

Signature of Insured _____ Date _____

List Name and Address of Spouse's Employer

Name _____

Address _____

_____

If you are not married but are claiming dependent children you must supply us with the following information.

Natural Parent Name _____

Address _____

Employer Name _____

Address _____

If any of your natural children do not live with you, please provide the name and address of the person with custody.

Name _____

Address _____

_____

If you are not adding a Step Child, or you are the legal guardian of said child, you must supply information to show legal custody. (I.e. Tax return, legal documents such as court order or adoption papers.)

COMPLETE SECTION BELOW IF YOU OR ANY OF YOUR DEPENDENTS HAVE ADDITIONAL HEALTH INSURANCE
Supply Information As It Appears On Your Policy Or I.D. Card

		GROUP OR POLICY NO.	TYPE OF COVERAGE	IF GROUP—NAME OF CONTRACT HOLDER (Employer, Fund, Association, etc.)
Insured Name ▷			☐ Individual	
Group ▷			☐ Group	
Insured Name ▷			☐ Individual	
Group ▷			☐ Group	
Insured Name ▷			☐ Individual	
Group ▷			☐ Group	
Insured Name ▷			☐ Individual	
Group ▷			☐ Group	

IMPORTANT: MAKE SURE YOU HAVE SIGNED AND DATED THE FRONT OF THE CARD, AND THAT YOU HAVE COMPLETED THE BENEFICIARY SECTION, OR HAVE FILED SEPARATE BENEFICIARY DESIGNATIONS FOR EACH FUND. (CALL OR WRITE FUND OFFICE FOR APPROPRIATE FORMS.)

FOR FUND USE

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