UNITED HEALTH and WELFARE FUND

ENROLLMENT APPLICATION

LAST NAME	FIRST NAME	M.I.	SEX	SOC. SEC. NO.

Full Home Address	Apt #	CITY	STATE	ZIP CODE

Single Married Divorced Widowed Birth Date: ___/___/___

Marital Status - Circle ONE Above ONLY

Home # ( ) _____ **Work #** ( ) _____ **E-MAIL:** _____

Additional Information:

	Last	First			
Spouse:	**Name:**		**SEX:**	**SSN#**	**DOB:**
Dep. Child	**Name:**		**SEX:**	**SS #**	**DOB:**
Dep. Child	**Name:**		**SEX:**	**SS #**	**DOB:**
Dep. Child	**Name:**		**SEX:**	**SS #**	**DOB:**

Prior Health Insurance:

Carrier Name: _____

Coverage Began: ___/___/___

Coverage Ended: ___/___/___

Are you covered by any other Health Ins. or Medicare?

No _____ **Yes** _____ indicate:

Ins. Co. Name: _____

Type of Coverage: _____

Policy # _____

Coverage Start: ___/___/___

EMPLOYER : _____

ADDRESS: _____

City, State: _____

Zip Code: _____

Your signature is required: _____ Date: _____

Plan Type: ☐ Diamond 1K ☐ Emerald 3K ☐ Ruby 5K

FOR OFFICE USE ONLY

Rcvd by: _____ **Coverage Type:** _____ **Eligible:** _____