

SIDE 1  
(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	
NAME OF PRESENT EMPLOYER				MONTH	DAY	YEAR

\*\*\*\* 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 <small>*Please provide name of school if any dependents are full-time students</small>

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

SIDE 2

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

\*\*\* 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**

