ENROLLMENT CARD
UFCW Local 152 Health & Welfare Fund • 27 Roland Ave, Suite 100 • Mt. Laurel, NJ 08054
800-555-4959

NAME (LAST) (FIRST) (MIDDLE) (SUFFIX)	Social Security #
	Phone #

ADDRESS (STREET) APT # (CITY) (STATE) (ZIP)	DATE OF BIRTH / /

FOR FUND USE ONLY	NAME OF EMPLOYER	LOCAL UNION #	SEX
EMP. #			____Male ____Female
PLAN:	DATE OF HIRE		(Circle one)
EFFECTIVE DATE:	/ /		Fulltime or Part Time

Type of Application	Name of Spouse (First & Last Name)	Spouse's Birth Date / /
☐ New Participant ☐ Add Dependent(s)	Primary Beneficiary (First & Last Name)	Address & SSN # / Relationship
☐ Reinstated - Date Returned to Work ___/___/____		
☐ Change in Benefits ☐ Change of Address	Contingent Beneficiary (First & Last Name)	Address & SSN # / Relationship

Marital Status:	Number Eligible Dependent Children _____	**SIGN**
☐ Married ☐ Single		**HERE ➜** _____
☐ Divorced ☐ Separated		**Date Signed** _____
☐ Widowed		(please complete back of card)
Date of above event:_____		

Print the name of each dependent below. Dependents include your eligible spouse and eligible children under 26 years of age only. All eligible dependents must be listed and an Adult Enrollment Form is required to be completed for dependents over age 19. Please return all required documents with this card (marriage certificate, spouse proof of residency, birth certificates, etc.)

LIST FIRST, LAST & MIDDLE NAME OF EACH ELIGIBLE DEPENDENT BELOW (DO NOT REPEAT YOUR OWN NAME)	**SOCIAL SECURITY#**	**BIRTH DATE**			**RELATIONSHIP**			
		MO.	**DAY**	**YEAR**	**SPOUSE**	**SON**	**DAUGHTER**	**OTHER**

DOES YOUR SPOUSE HAVE OTHER INSURANCE? ☐ YES ☐ NO IF YES, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW:

SPOUSE NAME:	SS#:
EMPLOYER NAME:	PHONE #
EMPLOYER ADDRESS:	
INSURANCE CARRIER:	PHONE #
EFFECTIVE DATE OF POLICY:	