

MEMBERS LAST NAME	FIRST NAME	INIT.	SOC. SECURITY NO.	MALE FEMALE
STREET ADDRESS		APT. NO.	DATE OF BIRTH	HOME/CELL #
CITY	STATE	ZIP CODE	YOUR E-MAIL ADDRESS	MARRIED SINGLE DIVORCED WIDOW/ER
SHOP NAME	JOB CLASS		DATE HIRED	

COMPLETE THE FOLLOWING FOR YOUR SPOUSE AND ALL DEPENDENT CHILDREN.

FIRST & LAST NAME	DATE OF BIRTH	SEX	SOC. SEC. NUMBER	RELATIONSHIP
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				

YOU MUST COMPLETE REVERSE SIDE OF THIS CARD

TO COVER YOUR SPOUSE UNDER THE HEATH PLAN PROVIDE US WITH A COPY OF YOUR MARRIAGE LICENSE
TO COVER YOUR DEPENDENT CHILDREN UNDER THE HEALTH PLAN PROVIDE US WITH A COPY OF THEIR BIRTH CERTIFICATE
IF NOT YOUR BIOLOGICAL CHILD, DOCUMENTS ESTABLISHING YOUR RELATIONSHIP TO THE CHILD (EX: ADOPTION PAPERS

IF MARRIED, COMPLETE THIS SECTION.

DATE OF MARRIAGE	CITY,