ADMINISTERED BY
UNITED
ADMINISTRATIVE
SERVICES

PLEASE PRINT IN INK OR TYPE:

BAY AREA ROOFERS HEALTH & WELFARE PLAN
GROUP INSURANCE ENROLLMENT CARD

P.O. BOX 5057 SAN JOSE, CA 95150

CLAIMS CANNOT BE PROCESSED UNLESS
YOUR ENROLLMENT CARD IS ON FILE

TRUST FUND USE ONLY
[ ] NEW EMPLOYEE [ ] CHANGE
[ ] OPEN ENROLL. [ ] COBRA
[ ] DELETION
INSURANCE EFF. DATE _____
DATE _____ INITIAL _____

PARTICIPANT INFORMATION

_____ _____ _____ ___/___/___ ___/___/___
LAST FIRST M.I. SOCIAL SECURITY NO. DATE OF BIRTH

_____ _____ _____ _____
ADDRESS CITY STATE ZIP CODE

LOCAL NO. _____ [ ] Male [ ] Female RETIRED [ ] Yes [ ] No EMPLOYER _____

ARE YOU ENROLLING AS A BENEFICIARY OF A DECEASED PARTICIPANT? [ ] Yes [ ] No

IF YES, PLEASE PROVIDE DECEASED PARTICIPANT'S NAME _____ SOC. SEC. NO. ___/___/___

MARRIAGE AND DEPENDENT INFORMATION

DEPENDENT INFORMATION

NAME	DATE OF BIRTH	SOC. SEC. #	RELATIONSHIP	ADDRESS (IF DIFFERENT FROM YOU)
	___/___/___	___/___/___		
	___/___/___	___/___/___		
	___/___/___	___/___/___		
	___/___/___	___/___/___		
	___/___/___	___/___/___		
	___/___/___	___/___/___		
	___/___/___	___/___/___		

ARE ANY DEPENDENTS OVER AGE 18 FULL TIME STUDENTS [ ] Yes [ ] No IF YES, PROVIDE THE FOLLOWING INFORMATION:

_____ _____
NAME OF CHILD NAME OF SCHOOL

_____ _____
NAME OF CHILD NAME OF SCHOOL

LIST ADDITIONAL MARRIAGE, DEPENDENT AND BENEFICIARY INFORMATION ON REVERSE SIDE

CHECK ONE:

[ ] SINGLE [ ] MARRIED ___/___/___ (MO. DAY YR.) [ ] SEPARATED ___/___/___ (MO. DAY YR.) [ ] DIVORCED ___/___/___ (MO. DAY YR.) [ ] WIDOWED ___/___/___ (MO. DAY YR.)

NAME AND ADDRESS OF SPOUSES INSURANCE CARRIER

IF YOU HAVE DEPENDENT CHILDREN WITH A DIVORCED SPOUSE, PROVIDE THE FOLLOWING INFORMATION ABOUT DIVORCED SPOUSE:

LAST NAME | FIRST NAME | M.I. | SOCIAL SECURITY NO. | DATE OF BIRTH

ADDRESS | CITY | STATE | ZIP CODE

NAME AND ADDRESS OF DIVORCED SPOUSES INSURANCE CARRIER

BENEFICIARY INFORMATION

NAME (LAST) OF BENEFICIARY | FIRST NAME | M.I. | DATE OF BIRTH | RELATIONSHIP

ADDRESS OF BENEFICIARY | CITY | STATE | ZIP CODE

IF THE BENEFICIARY DIES BEFORE ME, I DESIGNATE AS CONTINGENT BENEFICIARY:

NAME (LAST) OF CONTINGENT BENEFICIARY | FIRST NAME | M.I. | DATE OF BIRTH | RELATIONSHIP

ADDRESS OF CONTINGENT BENEFICIARY | CITY | STATE | ZIP CODE

IF BENEFICIARY IS A MINOR, PLEASE PROVIDE NAME OF GUARDIAN:

ADDRESS OF GUARDIAN | CITY | STATE | ZIP CODE

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY THE TRUST FUND ADMINISTRATOR OF ANY CHANGE OF ADDRESS FOR MYSELF OR MY DEPENDENTS. I HEREBY CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION GIVEN IN THIS FORM IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE | DATE SIGNED