TEAMSTER'S LOCAL 671 HEALTH SERVICES AND INSURANCE PLAN

LAST NAME PLEASE PRINT	FIRST NAME IN FULL	MIDDLE NAME IN FULL	SEX
HOME ADDRESS	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	TELEPHONE NUMBER	PRESENT EMPLOYER	

DATE OF BIRTH — MONTH | DAY | YEAR

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

ARE YOU OR ANY DEPENDENTS COVERED UNDER ANY OTHER GROUP HEALTH INSURANCE?

☐ YES ☐ NO IF YES, PLEASE COMPLETE INFORMATION BELOW:

DEATH BENEFITS PAYABLE TO: NAME & ADDRESS

INSURANCE COMPANY NAME:

INSURANCE COMPANY ADDRESS:

INSURANCE COMPANY TELEPHONE #:

POLICY-HOLDER NAME: | POLICY NUMBER:

EFFECTIVE DATE:

RELATIONSHIP

☐ FAMILY ☐ EMPLOYEE ONLY ☐ EMPLOYEE & CHILDREN

☐ MEDICAL ☐ DENTAL

MEMBER'S SIGNATURE

EMAIL ADDRESS DATE CARD SIGNED

PLEASE COMPLETE REVERSE SIDE

1

THE HEALTH SERVICES OFFICE MAY REQUIRE YOU TO ESTABLISH THE ELIGIBILITY STATUS OF THE DEPENDENTS YOU LIST BELOW ACCORDING TO THE RULES LISTED IN THE SPD.

LIST BELOW THE NAMES AND SOCIAL SECURITY NUMBERS OF YOUR SPOUSE AND UNMARRIED CHILDREN UNDER 26 YEARS OF AGE

LIST NAMES IN ORDER OF AGE — ELDEST FIRST				CHECK (✓) RELATIONSHIP			DATE OF BIRTH		
FIRST	MIDDLE INIT.	LAST	SOC. SEC. NO.	SPOUSE	SON	DAUGHTER	MO.	DAY	YEAR

FOR OFFICE USE ONLY

EFFECTIVE DATE		CANCELLATION DATE	
1	4	1	4
2	5	2	5
3	6	3	6