PAMCAH - UA LOCAL 675 TRUST FUNDS

PERSONNEL HISTORY CARD ---- Please Print

LAST NAME: **FIRST NAME:** **MIDDLE NAME:**

SSN#: **DOB:** **GENDER:**

MAILING ADDRESS: **CITY:** **STATE:** **ZIP:**

PHONE NO: **EMAIL ADDRESS:**

NAME OF CURRENT EMPLOYER: **OCCUPATION:**

DEATH BENEFITS TO BE PAID TO: **RELATIONSHIP:**

ADDRESS OF BENEFICIARY:

MEDICARE HIC/MBI NUMBER:

DEPENDENTS: (List below name of spouse and eligible children under 26 years of age. List in order of age, eldest first)

NAME	SSN	DOB	RELATIONSHIP

Does your spouse work 20 or more hours a week? ☐ Yes ☐ No
Does your spouse's employer provide medical coverage? ☐ Yes ☐ No
If yes, did your spouse elect to take the medical coverage? ☐ Yes ☐ No

Does your dependent child work 20 or more hours a week? ☐ Yes ☐ No
Does your dependent child's employer provide medical coverage? ☐ Yes ☐ No
If yes, did your dependent child elect to take the medical coverage? ☐ Yes ☐ No

Do you or your dependents have any other medical, drug, vision or dental coverage? ☐ Yes ☐ No
if you answered yes to any of these questions, please fill out table below:

NAME OF INSURED	EMPLOYER	NAME OF INSURANCE (HMSA, HDS, etc)

EFF DATE	GROUP #	MEMBERSHIP #	PHONE #

SIGNATURE (member) : DATE:

SIGNATURE (spouse) : DATE:

Notice: By completing and signing this form, you are certifying that all information is correct and accurate. Ineligible dependents of members will be terminated from the plan. In the event of each signer's misrepresentation, PAMCAH-UA Local 675 Trust Funds reserves the right to recover any payments made to or for the benefit of ineligible members and dependents.