



**METAL TRADES WELFARE FUND
 HEALTH INSURANCE ENROLLMENT FORM**

**Report any change in this information to the Fund Office IMMEDIATELY.
 This Information Supersedes All Information Now on File.**

Book Number _____ Social Security Number _____

Name _____ Date of Birth _____

Address _____ Apt. # _____

_____ City _____ State _____ Zip _____

_____ Home Telephone _____ Mobile _____ E-mail _____

Check One (√) Married Single Widowed Divorced Legally Separated

All fields in this section are optional, answering these questions is your choice.
 You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a or Spanish origin? Select all that apply.

- No, not of Hispanic, Latino/a, or Spanish origin Yes, Mexican, Mexican American, Chicano/a
 Yes, Puerto Rican Yes, Cuban
 Yes, another Hispanic, Latino/a, or Spanish origin
 I choose not to answer

What's your race? Select all that apply.

- American Indian or Alaska Native Asian Indian Black or African American
 Chinese Filipino Guamanian or Chamorro Japanese
 Korean Native Hawaiian Other Asian Other Pacific islander
 Samoan Vietnamese White
 I choose not to answer

Certification. I understand that if I improperly enroll any dependent for coverage under the Fund or fail to timely notify the Fund if a dependent becomes ineligible for coverage, via divorce, etc, I will be responsible for all costs incurred by the Welfare Fund, for any claims or premiums paid for the ineligible individual and I am aware I may also have my and my dependents coverage suspended and/or terminated.

Participant Signature _____

Date _____



