

***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 phone \_\_\_\_\_ 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

