PAINTERS AND ALLIED TRADES DISTRICT COUNCIL #82 HEALTH CARE PLAN
Complete and return in order to assure accurate handling.

FULL NAME _____
LAST FIRST MIDDLE

ADDRESS _____
STREET CITY STATE ZIP CODE

SOCIAL SECURITY NO. _____ DATE OF BIRTH _____
MONTH DAY YEAR

LOCAL UNION NO. _____ DATE ENTRY INTO UNION _____ SEX _____

MARITAL STATUS (Please check one): ❑ MARRIED ❑ SINGLE ❑ DIVORCED

SPOUSE NAME _____
LAST FIRST MIDDLE

SPOUSE SOC. SECURITY NO. _____ DATE OF BIRTH _____

Name of Beneficiary	Relationship	Address

CARD IS NOT VALID UNLESS DATED AND SIGNED

X _____
YOUR SIGNATURE IN FULL DATE

Print name of each dependent below. Dependents who may be included in this application are your lawful spouse and children under 26 years of age only. All eligible dependents must be listed.

FIRST NAME (and last name if different than yours) OF ALL ELIGIBLE DEPENDENTS AND SOCIAL SECURITY NUMBER (Do not repeat you name below)	BIRTH DATE			RELATIONSHIP			
	Month	Day	Year	Son	Daughter	Step Son	Step Daughter
Soc. Sec. #							
Soc. Sec. #							
Soc. Sec. #							
Soc. Sec. #							
Soc. Sec. #							
Soc. Sec. #							
Soc. Sec. #							