APPLICATION FOR ENROLLMENT OR CHANGE IN THE MEDICAL REIMBURSEMENT AND LOSS OF TIME TRUST PLAN COVERAGE FOR MEMBERS OF HPFFA MEDICAL TRUST 341.

LAST NAME	FIRST NAME	MIDDLE INITIAL

HOME STREET ADDRESS	CITY AND STATE	ZIP CODE

PAYROLL NUMBER	STATION & SHIFT	HOME PHONE NUMBER	SOCIAL SECURITY
		( )-	

DATE OF BIRTH	SEX	MARITAL STATUS	IF MARRIED, DATE OF MARRIAGE OR DATE OF DIVORCE
	☐ MALE ☐ FEMALE	☐ MARRIED ☐ WIDOW ☐ SEPARATED ☐ SINGLE ☐ WIDOWER ☐ DIVORCED	

CHECK APPROPRIATE BOX(ES):		COVERAGE APPLIED FOR (CHECK ONE):
☐ INITIAL ENROLLMENT ☐ CHANGE REQUEST FOR:	☐ NAME CHANGE ☐ UPDATE INFO. ☐ ADD DEP.'(S) ☐ REMOVE DEP.'(S)	☐ SELF ONLY ☐ SELF & 1 DEPENDENT ☐ SELF & 2 OR MORE DEPENDENTS

NAMES OF DEPENDENTS TO BE ENROLLED, ADDED, OR REMOVED

ENROLL OR ADD*	REMOVE	PRINT NAME (IN FULL) & MIDDLE INITIAL INCLUDE CHILD'S LAST NAME (IF DIFFERENT)	RELAT.	SEX (M)	SEX (F)	BIRTHDATE MO	DAY	YEAR
			SPOUSE					
			CHILD					

* LATE ENTRANTS PENALTIES MAY APPLY IF THE REQUEST FOR ADDING COVERAGE FOR A MEMBER OR A DEPENDENT IS RECEIVED MORE THAN 31 DAYS AFTER THAT PERSON FIRST BECAME ELIGIBLE.

I HEREBY CERTIFY that the information on this APPLICATION is made by me and is true and complete to the best of my knowledge, and that it is correctly and fully recorded. I hereby make Application for Enrollment or Change in the Medical Reimbursement and Loss of Time Trust Plan COVERAGE for Members of HPFFA LOCAL 341 of which I am a MEMBER. I understand I must continue as a MEMBER to be Eligible to Continue COVERAGE. I also understand that no COVERAGE or Change in COVERAGE will be effective unless and until it is approved by LOCAL 341 or their ADMINISTRATORS.

SIGNATURE OF AGENT ______________________

DATE SIGNED ____________ SIGNATURE OF MEMBER ______________________