UA Local 190
Health and Welfare Plan
New Member Application

A. Coverage Information

Health Coverage:	If YES, please check one coverage type:
❑ Yes ❑ No	❑ Employee Only ❑ Emp. & One ❑ Emp. & Two or more

B. Applicant and Family Information

Name: Last	First:	Middle	Cell Phone Number: ( )	Home Phone number: ( )
Address: Street	City	State	Zip	County
Are you: ❑ Single ❑ Married ❑ Separated ❑ Divorce ❑ Widowed				
Email Address:				

Instructions: Please complete below for each eligible family member you want covered, including yourself. In order to complete, the enrollment. ***WE MUST*** have a ***COPY*** of each member's birth certificate and a copy of your marriage license, if applicable.

Important: In last column, check "yes" **only** if other group health insurance will remain in effect.

First Name: Middle Last Name	**Sex M/F**	**Relationship to Applicant**	**Date of Birth**			**Social Security Number**	**Medicare**	**Other Group Insurance**
			M	**D**	**Y**			
00 Applicant		SELF					❑ Yes ❑ No	❑ Yes ❑ No
01 Spouse							❑ Yes ❑ No	❑ Yes ❑ No
02 Child							❑ Yes ❑ No	❑ Yes ❑ No
03 Child							❑ Yes ❑ No	❑ Yes ❑ No
04 Child							❑ Yes ❑ No	❑ Yes ❑ No
05 Child							❑ Yes ❑ No	❑ Yes ❑ No

Medicare/Other coverage information: If you or your dependents checked "Yes" to being enrolled in Medicare or Other Coverage, please provide the following information.

Name:	**Medicare/Other Coverage Number:**	**Part A/Part B Effective Date:**	**Reason for other coverage:**
01			
02			

I certify that the above information contained in the application is correct to the best of my knowledge and belief:

_____ _____

Applicants Signature Date