77 Huyshope Avenue, Hartford, Connecticut 06106-7001
Phone: 1-800-227-4744 Fax: 1-860-947-8080

ENROLLMENT FORM

PLANILLA DE INSCRIPCION

YOU MUST ANSWER ALL QUESTIONS AND PRINT CLEARLY IN INK
(THIS FORM IS STRICTLY CONFIDENTIAL)

DEBE CONTESTAR LAS PREGUNTAS CLARAMENTE EN TINTA Y CON LETRA DE MOLDE
(ESTA PLANILLA ES ESTRICTUMENTE CONFIDENCIAL)

PLEASE CHECK APPROPRIATE BOX: □ New Enrollment □ Address Change Only □ Add/Remove Spouse or Child □ Change Beneficiary

1- PARTICIPANT INFORMATION *La informacion de identificacion personal*

Participant Name (Last, First, Middle Initial) *Nombre del Miembro*		Social Security *de Seguro Social*	
Current Street Address *Domicilio*	City *Ciudad*	State *Estado*	Zip *Zona Postal*
Home Telephone *Area y No. de telefono* ( )	Date of Birth *Fecha de Nacimiento*	Sex *Sexo*	Marital Status *Estado Civi* Single □ Married □ Separated □ Divorced □

2- EMPLOYMENT INFORMATION *Escriba la informacion de su empleo*

Name of Employer *Lugar de trabajo actual*		Work Telephone *Trabajo Telefono* ( )	
Employer Street Address *Direccion*	City *Ciudad*	State *Estado*	Zip *Zona Postal*
Date of Hire: *Fecha de Empleo* Full Time □ *Tiempo Completo* Part Time □ *Tiempo Parcial*	Hours Per Week on hire date: *Horas por semana dia de contrato* Hourly Rate: $ *Porcentaje por hora*	Job Classification: *Tipo de Trabajo* Department: *Depto*	

Do you currently work a second job with a different 1199 Employer? **Yes** *Si* □ **No** *No* □
If "Yes" complete the following information for your second 1199 job
Si tiene un Segundo trabajo con la 1199 nombre el otro lugar donde trabaja

Name of Second Current 1199 Employer *Lugar de trabajo actual*		Work Telephone *Trabajo Telefono* ( )	
Employer Street Address *Direccion*	City *Ciudad*	State *Estado*	Zip *Zona Postal*
Date of Hire: *Fecha de Empleo* Full Time □ *Tiempo Completo* Part Time □ *Tiempo Parcial*	Hours Per Week: *Horas por semana dia de contrato* Hourly Rate: $ *Porcentaje por hora*	Job Classification: *Tipo de Trabajo* Department: *Depto*	

Previous Employment in the Health Care Field. Please list the last two (2) previous jobs held in the Health Care Field
Previos Empleos en el Campo de Cuidados de Salud

1. Name of Previous Health Care Employer *Employer Patrono*			Was this job with an 1199 Employer *Posicion de 1199* Yes *Si* □ No *No* □
City *Ciudad*	State *Estado*	Date Employment Began *Fecha del Empleo*	Date Employment Ended *Fecha de Alta*
2. Name of Previous Health Care Employer *Employer Patrono*			Was this job with an 1199 Employer *Posicion de 1199* Yes *Si* □ No *No* □
City *Ciudad*	State *Estado*	Date Employment Began *Fecha del Empleo*	Date Employment Ended *Fecha de Alta*

3- ADD SPOUSE ***Attach a copy of marriage license*** (*cetificado de matrimonio*) ***and birth certificate*** (certificado de nacimiento).

Name of Spouse (Last, First, Middle Initial) *Nombre v apelido del esposala*	Marriage Date *Fecha de Nacimiento*	Spouse Date of Birth *Fecha de Nacimiento del esposola*	Spouse Social Security *No.del seguro social del esposola*

Does your spouse have other health care insurance? Yes *Si* □ (attach back and front copy of card) No *No* □
Tienen su esposala ylo hijos Seguro de Salud u otra poliza de Segura?

If "Yes" name of health insurance company or plan: ______________________ Policy/Group #: ______________
Nombre *de la companla de Seguro/Plan* *No. de la poliza*

DELETE SPOUSE *Attach a copy of Divorce Decree or Separation Agreement*

Name of Spouse (Last, First, Middle Initial) *Nombre v apelido del esposala*	Divorce/Separation Date	Spouse Date of Birth *Fecha de Nacimiento del esposola*	Spouse Social Security *No.del seguro social del esposola*

Continued On Other Side ▶

4- DEPENDENT CHILD INFORMATION* *Informacion Familiar.* **If you qualify for dependent coverage from the Fund, your dependent children, to age 26, are eligible for dependent coverage provided that your child is not eligible for other employer sponsored group health insurance through their own employment or their spouse's employment. To enroll Dependent Children a copy of each child's Birth Certificate or Adoption Documentation) is required.** *(Certificado de Nacimiento(s)/documentacion de adopcion.* **Physically and/or developmentally disabled children, age 26 or older, may be eligible for additional coverage. Call the Fund Office for information.**

1. Child's Name (Last, First, Middle Initial) *Nombre*	Social Security # *No de Seguro Social*	Son/Daughter *Parentesco*	D.O.B. *Fecha de nocimiento*
Street Address *Domicilio*	City *Ciudad*	State Estado	Zip *Zona Postal*

Is this child age 19-26? Yes *Si* □ No *No*□ If "Yes", Is this child employed? Yes *Si* □ No *No*□

If "Yes *Si*", Name of Employer *Nombre del Patrono*: ______________________ Full Time *Tiempo Completo* □ Part Time *Tiempo Parcial* □

Employer Address *Direccion*: ______________________ Telephone Number *No. de telefono*: (______)__________

Is this child eligible for employer sponsored group health coverage through their employment? Yes *Si* □ No *No*□
Is this child eligible for employer sponsored group health coverage through their spouse's employment? Yes *Si* □ No *No*□

If "Yes *Si*", Name and Address of Employer *Nombre del Patrono Direccion*: ______________________

2. Child's Name (Last, First, Middle Initial) *Nombre*	Social Security # *No de Seguro Social*	Son/Daughter *Parentesco*	D.O.B. *Fecha de nocimiento*
Street Address *Domicilio*	City *Ciudad*	State Estado	Zip *Zona Postal*

Is this child age 19-26? Yes *Si* □ No *No*□ If "Yes", Is this child employed? Yes *Si* □ No *No*□

If "Yes *Si*", Name of Employer *Nombre del Patrono*: ______________________ Full Time *Tiempo Completo* □ Part Time *Tiempo Parcial* □

Employer Address *Direccion*: ______________________ Telephone Number *No. de telefono*: (______)__________

Is this child eligible for employer sponsored group health coverage through their employment? Yes *Si* □ No *No*□
Is this child eligible for employer sponsored group health coverage through their spouse's employment? Yes *Si* □ No *No*□

If "Yes *Si*", Name and Address of Employer *Nombre del Patrono Direccion*: ______________________

FOR MEMBERS ELIGIBLE UNDER THE WELFARE FUND

5- BENEFICIARY INFORMATION- DEATH BENEFIT *Beneficio de Defuncion.* **List name and address of person(s) to whom your Death Benefit is to be paid. State how the person(s) are related to you (You cannot name yourself as a beneficiary). If a minor, state age, and give name of parents or guardian in "Remarks". If more than one person is to share the Death Benefit, indicate the percentage or share each is to receive in "Remarks".**
Indique nombre y direccion de la persona(s) que debe recibir el Beneficio de Defuncion. Indique el parentesco con la person(s). Si la persona es menor de edad senale la edad y el nombre de los padres o de la personal reponisable del menor en "Notas". Si mas de una persona va a compartir el Beneficio de Defuncion indique en "Notas" el percentage o parte que cada una debe recibir.

Effective Date of Change in Beneficiary			
PRIMARY Beneficiary Name (Last, First, Middle Initial) *Nombre del Beneficiario Primario*	Relationship to You *Parentesco con el Miembro*		Birth Date *Fecha de nacimiento*
Street Address *Domicilio del Beneficiario(ios) Primario*	City *Ciudad*	State *Estado*	Zip *Zona Postal*

If the PRIMARY beneficiary is deceased at the time of your death, list the name and address of the SECONDARY person(s) to whom your Death Benefit is to be paid. State how the person(s) are related to you (You cannot name yourself as a beneficiary). If a minor, state age, and give name of parents or guardian(s) in "Remarks". If more than one person is to share the Death Benefit, indicate the percentage or share each is to receive in "Remarks". ***Si el beneficiario primario ha fallecido al tiempo de su muerte, indique nombre y direccion de la persona(s) que debe recibir el Beneficio de Defuncion. Indique el parentesco con la person(s). Si la persona es menor de edad senale la edad y el nombre de los padres o de la persona responsable del menor en "Notas". Si mas de una persona va a compartir el Beneficio de Defuncion indique en "Notas" el percentage o parte que cada una debe recibir.***

SECONDARY Beneficiary Name (Last, First, Middle Initial) *Nombre del Beneficiario Secundario*	Relationship to You *Parentesco con el Miembro*		Birth Date *Fecha de nacimiento*
Street Address *Domicilio del Beneficiario(ios) Primario*	City *Ciudad*	State *Estado*	Zip *Zona Postal*
REMARKS: (Other Beneficiary) *Notas:*			

THIS INFORMATION MAY BE USED FOR PURPOSES OF UPDATING THE FUND'S RECORDS.
Esta informacion podrd usarse con el fin de poner al dia mi expediente personl.

THE FORGOING STATEMENTS ARE TO THE BEST OF MY KNOWLEDGE TRUE AND COMPLETE.
La declaracion anterior es totalmente clerta y es hecha en pleno ejercicio de mis facultades fisicas y mentales.

Participant Signature *Firma del Miembro* **X**______________________ Date *Fecha* ______________

****For an extra form "Additional Dependent Children Information Sheet," please call the Fund office.***