ENROLLMENT FORM
UAW Group Health and Welfare Fund
LOCAL 2326
PRINT ALL INFORMATION

-- --

Last Name *First Name* *M.I.* *Social Security Number*

Home Address *City* *State* *Zip*

Home Phone # *Cell #* *E-mail Address*

Date of Birth *Gender* *Marital Status: (Circle One)* *Single* *Married* *Divorced* *Widowed*

DENTAL ELECTION (IF APPLICABLE) CIRCLE YES OR NO

List Below Names of Your Spouse and All Dependent Children (up to age 26)
List Names in Order of Age – Oldest First

		Social Security No.	Relationship *Spouse*	*Son*	*Daughter*	Date of Birth *Month*	*Day*	*Year*
	☐ Add ☐ Remove ☐ Continue							
	☐ Add ☐ Remove ☐ Continue							
	☐ Add ☐ Remove ☐ Continue							
	☐ Add ☐ Remove ☐ Continue							
	☐ Add ☐ Remove ☐ Continue							

Welfare Fund Beneficiary Designations
(If applicable)

I hereby authorize the payment of any death benefits as follows:

Primary ***Contigent***

Name(Last, First, MI) Name(Last, First, MI)

Address Address

SSN *DOB* *Relationship* *SSN* *DOB* *Relationship*

Signature of Employee Date

UAW HEALTH & WELFARE FUND LOCAL 2326
COORDINATION OF BENEFITS FORM

PRINT ALL INFORMATION

Participant Last Name _____ Participant First Name _____ M.I. _____ Social Security Number _____

Home Address: _____

City _____ State _____ Zip code _____ Phone # _____

Please check here, sign and date below if no family members have medical/dental coverage ☐

Complete the following section for each family member and indicate below those that have **other** coverage

	Last Name, First Name and Middle Initial	Sex	DOB	Social Security Number	Please indicate here if member/dependent has other medical/dental coverage	Type of coverage- family/single/ parent/child(ren)	Please list name of other insurance carrier /plan or Medicare	Please include **copies** of all other medical and or dental **cards**
Participant		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date** _____			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Spouse		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date** _____			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date** _____			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date** _____			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge.

_____ Participant Signature

_____ Date

UAW HEALTH & WELFARE FUND LOCAL 2326
COORDINATION OF BENEFITS FORM
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Participant Last Name | Participant First Name | M.I. | Social Security Number

PAGE 2 - ADDITIONAL CHILDREN

Complete the following section for each child and indicate below those that have **other** coverage

	Last Name, First Name and Middle Initial	Sex	DOB	Social Security Number	Please indicate here if dependent has other medical/dental coverage and effective date	Type of coverage- family/single/ parent/child(ren)	Please list name of other insurance carrier /plan or Medicare	Please include **copies** of all other medical and or dental **cards**
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge.

Participant Signature | Date