UFCW LOCAL 360 HEALTH FUND

48 STILES LANE, SUITE 204, PINE BROOK, NJ 07058
TEL: (973) 299-6700 FAX: (973) 299-1288

ENROLLMENT FORM

MEMBER NAME: ______________________________________ID:___________________________ Company Name____________________________
DOB:____________________SSN:___________________________
Address: ____ City: _______________________ State: _________ Zip: _____________________
Phone: ____________________ Mobile: ______________________________ Email: _____________________________________

Complete this section if you are married:

Spouse First Name	Spouse Last Name	Spouse Date Of Birth	Spouse Soc.Sec.No.	Is Spouse employed?	Spouse other coverage?
				☐ YES ☐ NO	☐ YES ☐ NO

Complete this section if you have dependent children under age 26:

Dependent First Name	Dependent Last Name	Dependent DOB	Dependent Soc.Sec.No.	Relation To Member	Gender	DEP other coverage?
				☐ Child ☐ Stepchild ☐ Other	☐ M ☐ F	☐ Yes ☐ No
				☐ Child ☐ Stepchild ☐ Other	☐ M ☐ F	☐ Yes ☐ No
				☐ Child ☐ Stepchild ☐ Other	☐ M ☐ F	☐ Yes ☐ No
				☐ Child ☐ Stepchild ☐ Other	☐ M ☐ F	☐ Yes ☐ No
				☐ Child ☐ Stepchild ☐ Other	☐ M ☐ F	☐ Yes ☐ No
				☐ Child ☐ Stepchild ☐ Other	☐ M ☐ F	☐ Yes ☐ No

***Attach copy of marriage certificate for Spouse and birth certificate for Dependent for coverage to become effective**

I certify that all of the above information is true and complete. I understand that any misleading or incorrect statements render this enrollment void and may be cause for termination of my medical and other benefits or denial of claim payment by the UFCW Local 360 Health Fund. I hereby authorize any entities and references named herein to give information in responding to inquiries in connection with this enrollment. I release said entities from all liability for issuing information relative to the Local 360 Health Fund.

Dependent Signature: ____ Date Signed: ___________________________________