Local 103, I.B.E.W. – Health Benefit Plan Group Health Enrollment

Member Information: Date of Birth Social Security Number Last Name First Name MΙ Address Apt.# State Zip Code City Telephone Number Email **Date Completed** Marital Status: ☐ Single Married ☐ Male ☐ Female Sex: If yes, what is the name of the plan? **Dependent Information:** ☐ Spouse Only ☐ Spouse and Children My dependent coverage is for: ☐ Children Only ■ None If yes, what is the name of the plan? _ ☐ Husband ☐ Wife Last Name Date of Birth Social Security Number First Name MI ☐ Daughter☐ Son First Name Date of Birth Social Security Number ΜI ☐ Daughter☐ Son First Name Date of Birth Social Security Number MΙ ☐ Daughter☐ Son Date of Birth First Name MΙ Social Security Number ☐ Daughter☐ Son Last Name Date of Birth First Name ΜI Social Security Number ☐ Daughter☐ Son Social Security Number First Name MΙ Date of Birth ☐ Daughter☐ Son First Name Date of Birth Social Security Number ☐ Daughter☐ Son Last Name First Name MΙ Date of Birth Social Security Number ☐ Daughter☐ Son First Name ΜI Date of Birth Social Security Number ☐ Daughter☐ Son Last Name Date of Birth Social Security Number First Name MΙ Date Completed: ____/___/ Member Signature: _____