SHEET METAL WORKERS' LOCAL 36
BENEFIT FUNDS
2319 CHOUTEAU AVE., STE. 300
ST. LOUIS, MO 63103

ENROLLMENT FORM

Enrollment Data for INSURED	**Please neatly print response to all fields**

Full Name: (Last) (First) (Middle)

Home Address: (Street) (City) (State) (ZIP)

Home Phone Number:	**Cell Phone Number**:

Social Security Number:	**Date of Birth**:	**Sex**: ☐ Male ☐ Female	**Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Are you covered under any other medical or dental insurance? ☐ Yes ☐ No If "Yes," please list the following information →	Name of Insurance Carrier:
	Insurance Address:
	Policy Number:

Enrollment Data for *DEPENDENTS*	To enroll your dependents, please fill in the information below for each dependent you wish to cover.

Full Name (Last—First—Middle)	**Date of Birth (MM/DD/YY)**	**Relationship to Insured**	**Sex**	**Social Security Number**	**Address (only if different than Insured)**	**Other Insurance?**
			☐M ☐F			☐Y ☐N
			☐M ☐F			☐Y ☐N
			☐M ☐F			☐Y ☐N
			☐M ☐F			☐Y ☐N
			☐M ☐F			☐Y ☐N
			☐M ☐F			☐Y ☐N

***If you answered "Yes" to your dependents having additional coverage, please fully complete the information on the other side of this document.**

I, the undersigned, confirm that the above information is true and current to the best of my knowledge. I certify that all dependents I have listed above are eligible dependents under the terms of the plan and are eligible to be claimed by me as a dependent for Federal Income Tax purposes. I hereby authorize the release by or to the Benefit Consultants, Inc. any protected health infor-

Signature of Insured:	**Date:**

Please fill in this information only if you answered “Yes” to the “Other Insurance?” question in the Dependent Enrollment section.

Name of Dependent:
Name of Insurance Carrier:
Address of Insurance Carrier:
Policy Number:

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