MEMBERSHIP ENROLLMENT FORM

To enroll in the USW HRA Fund, please complete this form and return it to the Fund Office by mail, fax, or e-mail using the contact information provided below. Please return your enrollment information promptly, as your coverage cannot begin until the enrollment information is received. If you choose Dependant coverage, you must list your Dependents on this form. Only Dependents listed on your enrollment form will be entitled to coverage. Newborns must be added as Dependents and enrollment information must be submitted to the Fund within 15 months of the child's birth in order to be covered as of the child's date of birth.

Participant Information (Please print clearly)

Participant's Name	Social Security Number	Date of Birth
Participant's Address	City State	Zip
Phone Number	Email Address	Date of Hire
Spouse's Name	Social Security Number	Date of Birth
Dependent's Name	Social Security Number	Date of Birth
Dependent's Name	Social Security Number	Date of Birth
Dependent's Name	Social Security Number	Date of Birth
Dependent's Name	Social Security Number	Date of Birth

(Additional dependents should be listed on a second form.)

I acknowledge that any benefits to which I may become entitled are subject to the terms and conditions of the governing Plan documents and applicable law. I attest that I and my dependents are covered by group health plan coverage that meets the minimum value standard under the Affordable Care Act. I understand that I must promptly inform the Fund if and when I or my dependents are no longer enrolled in a group health plan that meets the minimum value standard under the Affordable Care Act

Signature of Participant _____ Date _____

Fund Office Use Only

Verified by: _____ Date: _____ Enrollment Packet Mailed by: _____ Date: _____

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