

EMPLOYMENT AND PRIOR HEALTHCARE QUESTIONNAIRE

Completion and return of this information allows us to update your record, eliminating a processing slowdown.

IN REFERENCE TO YOU, OUR MEMBER:

EMPLOYER'S NAME: _____

EMPLOYER'S ADDRESS: _____

CITY, STATE, ZIP: _____

EMPLOYER'S TELEPHONE NUMBER: _____

In the space that follows, provide the name, address, telephone number, policy number and certificate number of any health coverage you have had prior to your coverage with us. **If your prior policy has terminated in the last six months, the Fund Office will require a letter of termination from your insurance carrier.**

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____

POLICY NUMBER: _____ CERTIFICATE NUMBER: _____

IN REFERENCE TO YOUR SPOUSE:

Is your spouse employed? Yes No (Check One).

If yes, show the full name, complete address and telephone number of your spouse's employer.

SPOUSE'S EMPLOYER'S NAME: _____

SPOUSE'S EMPLOYER'S ADDRESS: _____

CITY, STATE, ZIP: _____

SPOUSE'S EMPLOYER'S TELEPHONE NUMBER: _____