UAW ENROLLMENT FORM

Strike Number: ____________

Local Union: ______ Unit: ______ Worksite: ________________________

☐ COBRA
☐ Life Insurance Only
Strike Department Use Only

MEMBER (FIRST, MI, LAST)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
STREET ADDRESS	APT. NO.	CITY	STATE	ZIP
TELEPHONE NUMBER	HIRE DATE	EMERGENCY CONTACT	CONTACT TELEPHONE NUMBER	

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

LIFE INSURANCE:

AMOUNT: $ | BENEFICIARY:

MEDICAL ASSISTANCE:

EFFECTIVE DATE: ____/____/____ | PRESENT MEDICAL PLAN: ____________

PRESENT COVERAGE:

☐ SINGLE ☐ MEMBER & SPOUSE ONLY

☐ FAMILY ☐ MEMBER & DEPENDENT CHILDREN ONLY

DO YOU OR YOUR DEPENDENTS HAVE LARGE MEDICAL BILLS?
(Cancer,Pregnancy,Heart Problems,Handicaps.Etc.)

☐ NO ☐ YES - See your strike representative

LIST DEPENDENTS PRESENTLY COVERED

	NAME (FIRST, MI, LAST)	SEX	DATE OF BIRTH	RELATIONSHIP (Spouse, Daughter, Son, Other)	ADDITIONAL INFORMATION (College, College Address, Handicaps, Etc)
1					
2					
3					
4					
5					
6					

IF YOU HAVE OTHER MEDICAL COVERAGE, PLEASE PROVIDE THIS INFORMATION BELOW:

If you or your dependents have coverage under another group health plan, please answer the following so that we may coordinate benefits with that group health plan, if appropriate. If there is no other group health plan, please indicate by answering N/A.

Name of Carrier ________________________________

Policy / Group Number ____________________ Effective Date of Coverage __________

Name(s) of Individual(s) Covered ________________________________

Payment of medical bills is available only for members of the bargaining unit who participate in the strike, under the rules and up to the limits established by the International Union. They terminate the day the strike ends.

I hereby agree to refund any monies to the UAW strike fund received from the company or its insured for any medical or prescription claims of COBRA premiums, which the UAW has paid on my behalf.

I hereby authorize any hospital, doctor, clinic or similar institution, who has treated me or one of my family members to furnish information regarding said treatment, including copies of all their records, to the UAW or its designee. A photostatic copy of this authorization shall be considered as effective and valid as the original.

________________________ ________________________
Signature Date

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