

To Be Completed By Human Resources *Maintain completed form for your records.*

Group Number 646888	Local Number	Billing Category 001	Date of Employment
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To Be Completed By Applicant

Check all boxes and complete all sections that apply.

Mail or fax the completed form to:

Cara Steelman
 Transport Workers Union
 1791 Hurstview Drive
 Hurst TX 76054

FAX: 817-282-1906

Your Name (Last, First, Middle)	Employee Number	Birth Date		<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Address	City	State	ZIP	Phone Number
Policyholder Name Transport Workers Union / Air Transport Division	Job Title/Occupation		Social Security Number	
Employer Name				
Hours Worked Per Week	Earnings \$_____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			

Change *Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.*

Name Change Former name _____

Other _____

Coverage *Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.*

Short Term Disability Voluntary STD

Signature I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____