

**AUTOMOTIVE PETROLEUM
AND ALLIED INDUSTRIES EMPLOYEES WELFARE FUND
MEMBER ANNUAL ENROLLMENT UPDATE FORM**

EMPLOYEE INFORMATION: To be completed by Member each year

If address and phone number of covered dependents are different from that of our member, please attach that information.

Name: (Last, First, MI) _____ Social Security # _____ Phone: Home: () _____

Address: (Street) _____ (City) _____ (State) _____ (Zip) _____ Work: () _____

Marital Status: ___ Single ___ Married: Date _____ ___ Separated: Date _____
 ___ Widowed: Date _____ ___ Divorced: Date _____

Family Information: Family Members to be Covered on this policy

All spaces below must be filled out for each family member. If "Other" is checked, please indicate the nature of that relationship and include any appropriate legal documents (ei; Birth Certificate, Court Order, or affidavits only **if not provided within the last 12 months**)

Relationship	Name Last	First	M.I.	Social Security #	Sex	Date of Birth Mo Day Yr
___ Self					M F	___/___/___
___ Spouse					M F	___/___/___
___ Son*						
___ Daughter*						
___ Other*					M F	___/___/___
___ Son*						
___ Daughter*						
___ Other*					M F	___/___/___
___ Son*						
___ Daughter*						
___ Other*					M F	___/___/___
___ Son*						
___ Daughter*						
___ Other*					M F	___/___/___

* If over 19 years of age -Provide Full-Time Student Status Document ♦ Additional Family Members Please list on back or separate

BENEFICIARY ASSIGNMENT (For Death Benefit only)

Beneficiary _____ Relationship _____

OTHER COVERAGE: complete or Write N/A (not applicable)

Other Health Insurance Coverage/Medicare, Medicaid

Name of Insured with Other Coverage _____ Birth date (Mo/Day/Yr) _____

Social Security # _____ Name of Employer _____

Name of Insurance Co. or Health & Welfare Plan _____ Effective Date _____

Address of Insurance Co. _____

Insurance Co. Phone # _____ Policy # _____ Group# _____

Who is Covered?
 ___insured ___ Spouse ___ Insured & Spouse ___ Insured & Children ___ Insured & Entire Family

Name of Anyone on Medicare? _____ Beneficiary No: _____

___ Medicare A Effective Date _____ Medicare B Effective Date: _____

Note: If Medicare recipient attach photocopy of Medicare Card

Please read the following carefully

- I understand that misrepresentation in answering the questions on this form may constitute insurance fraud under applicable State and Federal statutes.
- I understand that it is my responsibility to report to the plan any changes in the eligibility of my dependents or myself.
- Information can be verified through Public Records and sources available to the Fund.

Please sign agreement

Member Signature

Date