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

Group Number	Local Number	Billing Category	Date of Employment
646888		**001**	

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		☐ Male ☐ 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: ☐ Hour ☐ Week ☐ Month ☐ Year			

Are you currently insured under an employer sponsored STD plan? ☐ Yes ☐ No

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) ______________