HAGERSTOWN TEAMSTER AND MOTOR CARRIERS HEALTH AND WELFARE FUND

HealthReach Enrollment Form

Member Information

Social Security Number

Name

_____-_____-_____

_____ _____ _____

Last First MI

Address

_____ _____ _____ _____

Street City State Zip Code

Telephone No. ( )_____-_____ Date of Birth _____/_____/_____ Sex: ____M _____F

Email Address: _____

Dependent Information

1. Spouse: _____ _____/_____/_____ _____/_____/_____
   Name Date of Birth Date of Marriage
2. Dependent: _____ _____/_____/_____ _____
   Name Date of Birth Relationship
3. Dependent: _____ _____/_____/_____ _____
   Name Date of Birth Relationship
4. Dependent: _____ _____/_____/_____ _____
   Name Date of Birth Relationship
5. Dependent: _____ _____/_____/_____ _____
   Name Date of Birth Relationship
6. Dependent: _____ _____/_____/_____ _____
   Name Date of Birth Relationship

I (and my eligible dependents) acknowledge that the Plan requires enrollment in the HealthReach Wellness Program. I/We agree to cooperate and actively participate in the program if selected. I acknowledge that failure to cooperate or actively participate will result in higher calendar year deductibles ($500/individual and $1,000/family).

_____ _____

Signature of Member Date