

TEAMSTERS LOCAL 639 - EMPLOYERS HEALTH TRUST 3130 Ames Place, NE, Washington, DC 20018-1513

202-636-8181 Toll Free 1-800-983-2699

To be completed by MEMBER (please print, except for Signature)

Member's Name:						Member's Social		
	Last		First	MI		Security Number		
Address:						Member's		
	Street / P.O. Box					Date of Birth: Member's		
	City	State		Zip		Home Telephone:	()_	
Marital St	tatus: Single			Separated	********************	Male F	emale	
100000	Divorced*	0.000				Date Member Joi	ned Union:	_
*Please a	ttach copy of marria	ge certifi	cate or d	livorce decree.		December Francisco		
If Married	, Date of Marriage:	11	<u></u>	<u></u>		Present Employe		
Primary B	eneficiary (for Life Ir	surance	& AD&D	benefits):	Contingent*	Beneficiary (for Lif		& AD&D benefits):
Name:					Name:			
-	st	First		MI	Last	F	irst	MI
Address:				1978 4	Address: _	mile mile		-
	Street / P.O. Box				St	reet / P.O. Box		
	City	State		Zip	Cit	ty S	tate	Zip
Relations	nip to Member:				Relationship	to Member:		
Date of Bi	rth:				Date of Birth	======		
-	and your primary bene	ficiary is	deceased	, your contingent b				3) (0)
lf you wish	to divide your benefits onship to you, and the	among s	everal pe	rsons, you need to	fill out a separa		e names, addr	esses, dates of
Dependen	ts (refer to the revers	e side of	this car	d and/or the <i>Sun</i>	nmary Plan Des	cription for definiti	on of depen	dent):
3.50	nt children, please atta	ch a copy						
Name. 			Relation Spouse	nship to Member	Date o	f Birth S	Social Security Number	
-						and the Manager of Sall		
Note: If a	any dependent has other	insurance	coverage.	please list each den	endent's name and	d the name of the other	r insurance cor	nnany
Vame				Other Insurance Co				
Vame	THE TIES		Other Insurance Company					
*****************	*****************************	**********					**************	
					8-3			

Member's Signature

Date