HOLLOW METAL TRUST FUND
Health Plan Enrollment Information

PARTICIPANT INFORMATION:

Name:	Social Security Number:	UBC:
Street Address:	City, State & Zip:	Date of Birth:

Home Phone:	Cell Phone:	Other Phone:	Email:

Dependent Information:

List **SPOUSE** that you wish to enroll and attach photocopies of marriage certificate, current relationship status and Social Security card. Include proof of Spouse's date of birth if not indicated on marriage certificate. Please include a photocopy of his/her Medicare card, if applicable.

First Name	Last Name	Social Security Number	Date of Birth	Medicare Y/N?

List **DEPENDENT CHILDREN** and attach photocopy of birth certificate and social security card for each child. Please include copy of Medicare card, if applicable. Additional information may be required. If adding a Dependent Parent please enclose the appropriate documentation.

First Name	Last Name	Social Security Number	Date of Birth	Medicare Y/N?

CERTIFICATION

_____ _____

PARTICIPANT SIGNATURE **DATE SIGNED**

Please return this form, sign and dated, to the Fund Office
Hollow Metal Trust Fund
395 Hudson Street 9th Floor
New York, NY 10014