ENROLLMENT/ CHANGE FORM

Steelworkers Emergency Medical Program

60 Boulevard of the Allies, Pittsburgh, PA 15222

Fax: 412-562-2275

GROUP INFORMATION (To Be Completed by USW)

Group No. 15723	Group Name:	Employer Insurance Termination Date:	Coverage/change Effective Date Mo/Day/Yr.
Enroll ☐ Initial Enrollment ☐ Late Enrollment	Change ☐ Add Dependent (reason) _____ ☐ Delete Dependent (reason) _____ ☐ Address Change		Terminate ☐ Termination of Coverage **LU # 4-200** **Company: ROBERT WOOD JOHNSON**

MEMBER INFORMATION (To Be Completed by Member)

First Name	Middle Initial	Last Name	Social Security Number	Sex M / F	Date of Birth Mo/Day/Yr.

Home Address	City	State	Zip Code

Phone Numbers:	Last Date of Employer Coverage:

COVERED FAMILY MEMBERS

	First Name	Middle Initial	Last Name	Social Security Number	Sex M	Sex F	Date of Birth Mo/Day/Yr.
Spouse					☐	☐	
Dependent					☐	☐	
Dependent					☐	☐	
Dependent					☐	☐	
Dependent					☐	☐	
Dependent					☐	☐	
Dependent					☐	☐	

I certify that the information provided on this form is true to the best of my knowledge.

X	/ /	X	/ /
Member Signature	Date Signed Mo/Day/Yr.	USW Signature	Date Signed Mo/Day/Yr.

PLEASE USE THIS SIDE TO ***ENROLL*** IN THE USE EMERGENCY MEDICAL PROGRAM