Hagerstown Teamsters and Motor Carriers
Health and Pension Funds
10312 Remington Drive
Hagerstown, MD 21740-1483
Toll (800) 962-3972 Local (301) 733-2602
www.HagerstownTeamsters992Benefits.org

ENROLLMENT FORM

CHECK ALL THAT APPLY: ☐ **New Enrollment** ☐ **Adding Dependents** ☐ **Plan Change** ☐ **Address Change**

EMPLOYEE'S FULL LEGAL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ DATE OF BIRTH: _____ GENDER: (Mark One) Male ____ Female ____

PHONE NUMBER: (_____) _____ EMAIL:_____

EMPLOYER:_____DATE OF HIRE:_____LOCAL UNION #_____

MEDICAL PLAN (Provided By):	**PRESCRIPTION (Provided By):**	**DENTAL AND VISION:**
CAREFIRST	**CAREMARK**	**SELF FUNDED**

DEPENDENTS - (Including Spouse)

YOU MUST ATTACH LEGAL DOCUMENTATION THAT APPLIES TO ADD YOUR DEPENDENTS:

Birth Certificate(s) for children, Marriage Certificate for spouse, Legal Adoption papers, Legal Guardianship papers

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SSN	GENDER

I (and my eligible dependents) acknowledge that the Plan requires enrollment in the Health Reach 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).

MEMBER SIGNATURE: _____ **DATE:** _____