## HAGERSTOWN TEAMSTER AND MOTOR CARRIERS HEALTH AND WELFARE FUND HealthReach Enrollment Form

<u>lember Information</u>		Social Security Number
<u>ame</u>		
ast Address	First	MI
Street	City Sta	ate Zip Code
elephone No. ( )	Date of Birth/	/ Sex:MF
mail Address:		
Dependent Information		
1. Spouse:	, ,	/ /
Name		Date of Marriage
2. Dependent:Name	/	
3. Dependent:	/ /	
Name	Date of Birth	
4. Dependent:Name	Date of Birth	
5. Dependent:Name	Date of Birth	Relationship
6. Dependent:Name		 
Name  5. Dependent:  Name  6. Dependent:	Date of Birth  Date of Birth  Date of Birth  Date of Birth  at the Plan requires enrollmery participate in the program	Relationship  Relationship  Relationship  Relationship  ent in the HealthReach Wellness if selected. I acknowledge that fa
\$1,000/family).	·	•
 Signature of Member	 	