

EMPLOYEES SECURITY FUND OF THE ELECTRICAL PRODUCTS INDUSTRIES

158-11 HARRY VAN ARSDALE JR. AVENUE, FLUSHING, NY 11365-3017

Phone (718) 591-1100 Fax (718) 591-2189

ENROLLMENT FORM FOR NEW MEMBERS AND DEPENDENTS

Dear Participant:

The Employees Security Fund of the Electrical Product Industries provides health, welfare, and pension benefits to eligible employees of your company. To enroll, please complete the form below in full, sign and date it, and return it to the address listed above.

Important: Incomplete or improperly completed forms will be returned to the member.

Indicate whether this is a new address in the appropriate box below.

When submitting your enrollment form, please carefully follow these instructions:

- **Members must include copies of their Social Security card, birth certificate, and/or driver's license.** For eligible dependents, copies of their birth certificate and social security card must be attached.
- **All foreign documents must be accompanied by certified English translations.**
- **List all eligible dependents**, including full names and Social Security numbers exactly as they appear on their Social Security cards.
- **Photos of legal documents will not be accepted.**
- **Do not write "N/A"** in the Telephone or Cell Phone number fields.

Once your enrollment is processed and you become eligible, your hospital and prescription ID cards will be mailed to you. Your prompt attention to this matter is appreciated.

Thank you.
Employees Security Fund

(Please Print Clearly and DO Not cross anything out)

Participant:			Soc. Sec #:					
<i>First Name</i>	<i>M.I.</i>	<i>Last Name</i>						
Home Address:								
*NEW ADDRESS: Y <input type="checkbox"/> N <input type="checkbox"/>		<i>Number, Street, and Apt #</i>		<i>City</i>	<i>State</i>			
				<i>Zip Code</i>				
Telephone # ()		Birth Date:		Cell # ()				
Employer Name: _____			Personal E-Mail: _____					
Assigned Sex at Birth: Male <input type="checkbox"/> Female <input type="checkbox"/>		Current Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>						
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/>		Number of Dependent(s): _____						
<i>LIST YOUR ELIGIBLE DEPENDENTS (FULL NAMES AND SOC. SEC. # AS APPEARS ON CARDS)</i>								
<i>** (WE CANNOT ACCEPT THIS FORM WITHOUT COMPLETE INFORMATION) **</i>								
<i>First Name</i>	<i>Last Name</i>	<i>*Social Security #*</i>	<i>Assigned Sex at Birth</i>	<i>Current Sex (M/F/O)</i>	<i>Relation</i>	<i>Date of Birth</i>		
			<i>(M/F)</i>			<i>Mo.</i>	<i>Day</i>	<i>Year</i>
1.					<i>Spouse</i>			
2.					<i>Child</i>			
3.					<i>Child</i>			
4.					<i>Child</i>			

Participant's Signature: _____ Date: _____