(PLEASE COMPLETE)

HEALTH PROFESSIONALS AND ALLIED EMPLOYEES, AFT/AFL-CIO
RETIREE MEDICAL TRUST
140 SYLVAN AVENUE, SUITE 303, ENGLEWOOD CLIFFS, NJ 07632

PARTICIPANT INFORMATION CARD

PRINT ALL INFORMATION	Last Name	First Name	Middle Initial
HOME ADDRESS	Street and Number	City & State	Zip Code
Phone:		Email:	

Social Security No.	Gender: Female / Male	Date of Birth: Month / Date / Year
Name of Employer	Date of Hire	Full Time / Part Time / Limited Part Time	HPAE Local No.

Marital Status (Check One)	Single	Married	Widowed	Divorced Date	Legally Separated

List your Spouse or Domestic Partner

		Gender		Check Relationship		Date of Birth		
First Name	Last Name	M	F	Spouse	Domestic Partner	Month	Day	Year

List your dependents (Use back of card if additional space is needed)

First Name	Last Name	Date of Birth
1.		
2.		
3.		

I certify that all information on this form is true. correct and complete. The information on this card supersedes all previous participant information cards.

______________________________ ______________________

Signature of Participant Date

Please note: This is not an enrollment form. You are a participant of the program through the union contract. This form ensures that your contributions are properly credited and that you will receive the benefits to which you and/or your beneficiaries are entitled.

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