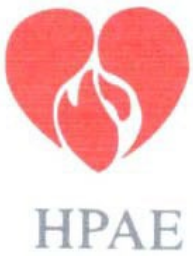


**(PLEASE COMPLETE)**

**HEALTH PROFESSIONALS AND ALLIED EMPLOYEES, AFT/AFL-CIO RETIREE MEDICAL TRUST**

**2 Gateway Center**
**603 Stanwix St., Suite 1500**
**Pittsburgh, PA 15222-1534**

# 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 ☐ Legally Separated | | |

**List your Spouse or Domestic Partner**

| | | Check Relationship | | Date of Birth | | |
|---|---|---|---|---|---|---|
| **First Name** | **Last Name** | **Spouse** | **Domestic Partner** | **Month** | **Date** | **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 have available the benefits to which you and/or your beneficiaries are entitled.**