(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 ☐ Legally Separated		

List your Spouse or Domestic Partner

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