PLEASE PRINT COMPLETE AND RETURN **BASIC DATA CARD** PLEASE PRINT

United Food and Commercial Workers Union Local 1189 and St. Paul Food Employers Health Care Plan

Full Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP CODE

Social Security No. _____ Date of Birth _____
MONTH DAY YEAR

Employer _____

☐ MALE
☐ FEMALE

No. of Children _____

Spouse's Name _____ Social Security No. _____

Dependent's Name _____ Social Security No. _____

Dependent's Name _____ Social Security No. _____

Full Name & Relationship of

BENEFICIARY _____
LAST FIRST MIDDLE INITIAL RELATIONSHIP

The Above Named Beneficiary Supercedes Any and All Beneficiaries Previously Designated

_____
Date Signed Signature of Employee