



**HEALTH PROFESSIONALS AND ALLIED EMPLOYEES, AFT/AFL-CIO
RETIREE MEDICAL TRUST
2185 LEMOINE AVENUE – SUITE 1-N, FORT LEE, NJ 07024**

HPAE

PARTICIPANT INFORMATION CARD

PRINT ALL INFORMATION	Last Name	First Name	Middle Initial
HOME ADDRESS	Street and Number	City & State	Zip Code
Social Security No.	Date of Birth Month _____ Year _____	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Home Telephone Number
Name of Employer	Date of Hire	<input type="checkbox"/> Full Time <input type="checkbox"/> _____ <input type="checkbox"/> Part Time <input type="checkbox"/> _____ <input type="checkbox"/> Limited Part Time <input type="checkbox"/> _____	HPAE Local No.
Marital Status (Check One)	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated
List your Spouse or Domestic Partner			
First Name	Last Name	Check Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Date of Birth 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 and correct. 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.