



HEALTH PROFESSIONALS AND ALLIED EMPLOYEES, AFT/AFL-CIO

RETIREE MEDICAL TRUST

140 SYLVAN AVENUE, SUITE 303, ENGLEWOOD CLIFFS, NJ 07632

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			
		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 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.