PLEASE PRINT

N.E.C.A. I.B.E.W. Local 480 Health and Welfare Plan

P.O. Box 721119 Byram, MS 39272

Name______________________ ______ ______________________
FIRST MI LAST

Address_________________________________Eff. Date___________

City_________________________State________ Zip_______________

SS___________________DOB____________ PPO Cigna/MHP

Phone _____________Local Union __________ Date Married_________

Dependents	SSN	DOB	Relationship

Do any dependents have other coverage? Yes ____No____ If yes, you must complete a re-enrollment form

Signature________________________________Date______________

Important: You must complete this card and return to Local 480 in order that our records may be complete.