

# AUTOMOBILE MECHANICS LOCAL 701 UNION AND INDUSTRY WELFARE FUND

500 WEST PLAINFIELD ROAD, COUNTRYSIDE, ILLINOIS 60525

## Request For Confirmation Of Required Information

	LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER	MEDICARE HEALTH INSURANCE CLAIM NUMBER ( IF APPLICABLE )	BIRTH DATE MM / DD / YY	FULL-TIME STUDENT? YES NO
PARTICIPANT	_____	_____	____-____-____	____-____-____	___/___/___	___ ___
SPOUSE	_____	_____	____-____-____	____-____-____	___/___/___	___ ___
DEPENDENT	_____	_____	____-____-____	____-____-____	___/___/___	___ ___
DEPENDENT	_____	_____	____-____-____	____-____-____	___/___/___	___ ___
DEPENDENT	_____	_____	____-____-____	____-____-____	___/___/___	___ ___
DEPENDENT	_____	_____	____-____-____	____-____-____	___/___/___	___ ___
DEPENDENT	_____	_____	____-____-____	____-____-____	___/___/___	___ ___
DEPENDENT	_____	_____	____-____-____	____-____-____	___/___/___	___ ___
DEPENDENT	_____	_____	____-____-____	____-____-____	___/___/___	___ ___
DEPENDENT	_____	_____	____-____-____	____-____-____	___/___/___	___ ___

PARTICIPANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Federal Law requires that the Fund Office obtain Social Security and Medicare Numbers.  
Please complete all applicable information and return the form in the enclosed self addressed envelope.