Retiree Chapter Enrollment Form

Employee Information

Name: ______________________________ **Date of Birth:** ______________

Social Security Number (SSN): ______________________ **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Home Address: ____

Telephone Number: __________________ **Email Address:** ______________________

Former Employer: ______________________________ **Number of Years:** ______

Check Benefits for Enrollment

Choose all that apply:

- ☐ Medicare Supplemental Plans
- ☐ General Vision Services (GVS)
- ☐ Healthplex Healthy Smiles Program

Application for Membership

I hereby apply for membership in the UBenefit Senior Supplemental Program and agree to be bound by the rules and regulations, Constitution, and By-Laws on the IUJAT.

Employee Name (Print): ______________________________

Employee Signature: ______________________________ **Date**: ______________

Return the completed form and a check for $180 to: Home Healthcare Workers of America, 145 Huguenot Street, Suite 420, New Rochelle, NY 10801 | Phone: (844) 220-8517 | Fax: (914) 352-0728 | info@hhwa.care

Retiree Chapter Spouse Enrollment Form

Employee Information

Name: ____ **Date of Birth:** _______________

Social Security Number (SSN): ________________________ **Gender:** ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Home Address: ____

Telephone Number: ___________________ **Email Address:** _______________________________

Former Employer: ____ **Number of Years:** _____

Check Benefits for Enrollment

Choose all that apply:

- ☐ Medicare Supplemental Plans
- ☐ General Vision Services (GVS)
- ☐ Healthplex Healthy Smiles Program

Application for Membership

I hereby apply for membership in the UBenefit Senior Supplemental Program and agree to be bound by the rules and regulations, Constitution, and By-Laws on the IUJAT.

Employee Name (Print): _____________________________________

Employee Signature: ____ **Date**: _______________

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