**Employment and Prior Healthcare Questionnaire**

Completion and return of this information allows us to update your record, eliminating a processing slowdown.

**IN REFERENCE TO YOU, OUR MEMBER:**

In the spaces that follow, provide the name, address, and telephone number of your previous employer or current employer as a previous employer may not be applicable:

Employer's Name: _____

Employer's Address: _____

City, State, ZIP: _____

Employer's Telephone Number: _____

In the space that follows, provide the name, address, telephone number, policy number and certificate number of any health coverage you have had prior to your coverage with us. **If your prior policy has terminated in the last six months the Fund Office will require a letter of termination from your insurance carrier.**

Name: _____

Address: _____

City, State, ZIP: _____

Telephone Number: _____

Policy Number: _____ Certificate Number: _____

**IN REFERENCE TO YOUR SPOUSE:**

Is your spouse employed? YES _____ NO _____ (Check One).

If yes, show the full name, complete address and telephone number of your spouse's employer.

Spouse's Employer's Name: _____

Spouse's Employer's Address: _____

City, State, ZIP: _____