ENROLLMENT FORM

ST. LOUIS GRAPHIC ARTS JOINT HEALTH & WELFARE FUND
14323 SOUTH OUTER FORTY ROAD, SUITE S106
CHESTERFIELD, MISSOURI 63017 (314) 878-1579

_____ _____ _____ _____-_____-_____ _____/_____/_____
(Last Name) (First Name) (MI) (Social Security Number) (Date of Birth)

_____ _____ _____ _____ _____-_____-_____
(Address) (City) (State) (Zip) (Phone Number)

Male ( ) Female ( ) Marital Status: Single ( ) Married ( ) - Date_____ Divorced ( ) - Date_____ Widowed ( ) - Date_____

Are you or any of your dependents covered under any other Group Medical Plan? ( )No ( )Yes--Person(s) Covered: _____

Name and address of other Group Medical Plan(s): _____Coverage Type: ( ) Single ( ) Family Effective Date_____

Are you or any of your dependents covered under Medicare? ( )No ( ) Yes--Person(s) Covered: _____ Eff. Date _____

I ELECT THE FOLLOWING COVERAGE- ( ) FAMILY ( ) INDIVIDUAL

DEPENDENT COVERAGE-I understand that there will be no open enrollment in the future for existing dependents whom I do not cover now. If an employee declines or discontinues coverage for a dependent (including a spouse), that dependent will not be permitted to enroll at a later date unless enrollment was declined or discontinued because of the existence of other group health insurance coverage. If such other group health coverage is lost, the dependent may be enrolled in the future, provided that enrollment is requested within 30 days after the loss of the other health coverage. The loss of other coverage must be due to marital separation, divorce, death, termination of employment, reduction in work hours or termination of employer contributions toward coverage, or exhaustion of COBRA continuation or state continuation. Special enrollment is not available if the previous coverage loss resulted from fraudulent activity or from nonpayment of premiums.

If you are retiree, please refer to section 1.2.10 of the January 1, 2001 Summary Plan Description for dependent coverage.

If you elect family coverage list all your eligible dependents – spouse and unmarried children under age 19 (age 23 if Full-Time Student)

Return a copy of Marriage License for spouse and Birth Certificates for all covered children

Name(Last, First,MI)	Date of Birth	Relationship	Gender	Social Security Number	Address if different from employee's
		Spouse			

IMPORTANT: To be effective, this form must be received by the Fund Office at the address listed above. Coverage of an employee and dependent is subject to the Eligibility Rules of the Plan.

I certify that the above information is correct and complete to the best of my knowledge.

_____ _____
(Signature) (Date)

_____
(Print Name)