Return to: **Steel Retirees Voluntary Benefits**
c/o Solidarity Health Network
4853 Galaxy Parkway, Suite K
Cleveland, OH 44128

1-866-634-9842

Steel Retirees Voluntary Benefits Trust

ENROLLMENT FORM

Please complete and return 15 days prior to the next Monthly Effective Date

RETIREE INFORMATION

NAME: _____ PHONE: (____) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: ____/____/____
MONTH DAY YEAR

ENROLLED IN MEDICARE?: YES ☐ NO ☐ MEDICARE ID #_____

Dental Only ☐ Dental/Vision ☐

SPOUSE AND DEPENDENT INFORMATION

SPOUSE NAME: _____

SOCIAL SECURITY # _____ DATE OF BIRTH: ____/____/____
MONTH DAY YEAR

SPOUSE ENROLLED IN MEDICARE?:YES ☐ NO ☐ MEDICARE ID # _____

Dental Only ☐ Dental/Vision ☐

DEPENDENT CHILD(REN) ☐ Check if you wish to enroll your dependent child(ren)

See Reverse Side to Add Dependent Children

Enrollment Signature	**Date**

I apply for enrollment in the Steel Retirees Voluntary Benefits Trust

DEPENDENT NAME: ________________________________ GENDER: ___________________________

SOCIAL SECURITY NUMBER: ______________________ DATE OF BIRTH: ___________________

DEPENDENT NAME: ________________________________ GENDER: ___________________________

SOCIAL SECURITY NUMBER: ______________________ DATE OF BIRTH: ___________________

DEPENDENT NAME: ________________________________ GENDER: ___________________________

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SOCIAL SECURITY NUMBER: ______________________ DATE OF BIRTH: ___________________

DEPENDENT NAME: ________________________________ GENDER: ___________________________

SOCIAL SECURITY NUMBER: ______________________ DATE OF BIRTH: ___________________

Enrollment Signature	**Date**

I attest that all the information is true and accurate. I certify that each dependent listed above is a valid dependent and that I will provide proof of dependency if it is requested by the Plan Sponsor or Administrator.