Automatic Sprinkler Local 281, U.A. Welfare Fund
Census Form

Please Print In Black Ink:

Personal Information

Social Security #: _____-_____-_____ Birthdate: _____/_____/_____

Name: _____ Phone: (_____) _____-_____

Address: _____

_____

_____

Spouse Information

Social Security #: _____-_____-_____ Birthdate: _____/_____/_____

Name: _____ Date of Marriage: _____/_____/_____

Dependent Information

Name	Birthdate	Sex	Social Security #
_____	_____/_____/_____	Male Female	_____-_____-_____
_____	_____/_____/_____	Male Female	_____-_____-_____
_____	_____/_____/_____	Male Female	_____-_____-_____
_____	_____/_____/_____	Male Female	_____-_____-_____

Other Insurance Carrier Information

Insured's Name: _____

Name of Carrier: _____

_____

Carrier Address: _____

_____

_____

Carrier Phone: (_____) _____-_____

Effective Date: _____/_____/_____

Coverage Types: (Please Circle)

Medical Dental Eye