

SPEEA-IFPTE LOCAL 2001 TEMPORARY MEDICAL COVERAGE APPLICATION FORM

* COMPLETE THIS PORTION ONLY IF WITHIN 10 CALENDAR DAYS OF YOUR EMPLOYMENT DATE.

Applicant _____
 Last Name (please print) First Name Initial Employee ID #

I do not have any dependents.
 I wish to sign up the following dependents for this temporary coverage.
 ▶ (If you need more space for dependents, use the back of this card.)

Applicant's Birth date _____
 Sex M F

NAME OF DEPENDENT	BIRTH DATE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Applicant's Signature _____ Date _____

*** NO EXCEPTIONS: YOUR APPLICATION MUST BE RECEIVED AT THE SPEEA OFFICE WITHIN 10 CALENDAR DAYS OF YOUR EMPLOYMENT TO RECEIVE THIS TEMPORARY MEDICAL COVERAGE!**

SPEEA-IFPTE LOCAL 2001 MEMBERSHIP APPLICATION

APPLICANT _____
 Last Name (please print) First Name Initial Employee ID #

ADDRESS _____
 Street (required if applying for temporary medical) Apt. No.

City State Zip Code

HOME PHONE (____) _____



(NOT REQUIRED)
 SPONSOR'S NAME _____
 (please print)

APPLICANT'S SIGNATURE _____

By application, I hereby request and authorize the Society of Professional Employees in Aerospace to represent me as my bargaining representative.

SPEEA-IFPTE LOCAL 2001 DUES DEDUCTION APPLICATION

Applicant _____
 Last Name (please print) First Name Initial Employee ID #

You are hereby authorized to deduct from my salary once monthly such sum as shall have been certified by the Society of Professional Engineering Employees in Aerospace as dues under the SPEEA constitution.

PLEASE REMIT ALL SUMS SO DEDUCTED TO SPEEA. THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL CANCELED BY ME.

In order to discontinue my dues obligation, I must satisfy the mandates found in the appropriate SPEEA Collective Bargaining Agreement.

APPLICANT SIGNATURE X _____
 (please print)

DO NOT SEPARATE