

# 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!**

DO NOT SEPARATE

## 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)

