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EMPLOYEES IN AEROSPACE
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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-IFTPE 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 (_____) _____

SPEEA
IFPTE LOCAL 2001

(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-IFTPE 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)