MEBA Medical & Benefits Plan 1007 Eastern Avenue Baltimore, MD 21202-4345 410-547-9111 \* 800-811-MEBA (6322) \* 410-547-6665 (Fax) \* www.mebaplans.org

## PERMANENT DATA FORM

COMPLETE BOTH PAGES OF THIS FORM , SIGN AND DATE WHERE INDICATED, AND RETURN TO THE PLAN OFFICE IN BALTIMORE

Member Name										
	Last Name			First Na	ame		Ini	tial		
Social Security Number										
Date of Birth (mm/dd/yyyy)				Sex (Select on	e)	<ul><li>Male</li><li>Female</li></ul>				
Home Telephone Number	(Area Code:									
Cellular Phone Number	(Area Code:									
E-mail address (If applicable)	@									
Affiliation (Check One)	O District No. 1-PCD, MEBA O Plan Employee O Union Employee O Other:									
Active/Pensioner (Check One)	O Active O Pensioner If Actively Employed, Name of Present Employer:						er:			
Marital Status (Check One)	○ Single ○ Married ○ Widowed ○ Divorced ○ Legally Separated									
Date Married, Widowed, Divorced or Legally Separated (mm/dd/yyyy)	O Married			○ Widov	dowed O Divorced O Legally Separated					
Permanent Address	Number & Stree	et								
(Home of Record):	City, State, Zip	)								
Mailing Address (if different than Permanent Address	Number & Stree	et								
above):	City, State, Zip									
DEPEN	DANTS TO BE A		ED TO YO 'FULL NA		OICAL (	COVERAGI	E			
				,,				STEP/GRAND		
LAST NAME FIRST NAME INITI	AL (MM/DD/YYYY)	D	EPENDANT S	SN		TO MEMBE	ER	CHILD CHECK IF		
					o Spot	CHECK ONI	E	• Yes		
					○ Chile		pted Child	o No		
						child o Gran	•			
If dependant is an adult child/adopted		_	_	-	Based Co	verage? (che	eck one) OY	'es ○ No		
Child's Employer Name		rage, complete the following sections  Child's Employer Address			Child's Employer Phone					
Cinia s Zinproyer i mino	Cima s Employer Au									
Child's Spouse's Employer Name	Child's Spouse's	Child's Spouse's Employer Address			Child's Spouse's Employer Phone					

LAST NAME	FIRST NAME	INITIAL	DATE OF BIRTH (MM/DD/YYYY)	DEPENDANT SSN	RELATIONSHIP TO MEMBER CHECK ONE	STEP/GRAND CHILD CHECK IF FT STUDENT		
					○ Child ○ Adopted Child	o Yes		
					○ Stepchild ○ Grandchild	o No		
If dependant is	an adult child/	adopted cl	nild, is he or she	eligible for Employment	Based Coverage? (check one) O	Yes O No		
		sed Covera		e following sections	-			
Child's Employer Name			Child's Employe	r Address	Child's Employer Phone			
Child's Spouse's Employer Name			Child's Spouse's	Employer Address	Child's Spouse's Employer Phone			
						L company (con the		
			DATE OF BIRTH		RELATIONSHIP	STEP/GRAND CHILD		
LAST NAME	FIRST NAME	INITIAL	(MM/DD/YYYY)	DEPENDANT SSN	TO MEMBER	CHECK IF		
					CHECK ONE	FT STUDENT		
					○ Child ○ Adopted Child	o Yes		
					○ Stepchild ○ Grandchild	o No		
					Based Coverage? (check one) O	Yes O No		
		sed Covera		e following sections				
Child's Employer	Name		Child's Employe	r Address	Child's Employer Phone			
Child's Spouse's Employer Name			Child's Spouse's	Employer Address	Child's Spouse's Employer Phone			
LAST NAME FIRST NAME INITIAL			DATE OF BIRTH		RELATIONSHIP	STEP/GRAND CHILD		
			(MM/DD/YYYY)	DEPENDANT SSN	TO MEMBER	CHECK IF		
		•	,		CHECK ONE	FT STUDENT		
					○ Child ○ Adopted Child	o Yes		
					○ Stepchild ○ Grandchild	o No		
If dependant is	an adult child/	adopted cl	nild, is he or she	eligible for Employment	Based Coverage? (check one) O	Yes O No		
-		-	*	e following sections	<i>g</i> : ( <del></del> - <del></del>			
Child's Employer			Child's Employe		Child's Employer Phone			
Child's Spouse's Employer Name		Child's Spouse's	Employer Address	Child's Spouse's Employer Phone				
<del>-</del>								
(Attac	ch a separate sh	eet to you	r Permanent Da	ata Form if you have mor	e than four Dependants)			
Signature of		_			Deta			
Employee					Date			

FORM IS NOT VALID IF NOT SIGNED AND DATED BY PARTICIPANT FORM WILL BE RETURNED IF NOT SIGNED AND DATED.