



Member Information Update Form

Member Information	Name: _____ Last First Last 4 Social Security Number: _____
Contact Information	Member's Address: _____ Number Street City State Zip code Home Phone: () _____ - _____ Cell Phone: () _____ - _____ E-mail Address: _____@_____
Verify Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated (If marital status ever changes, please contact TeamstersCare immediately)
Alternate Address	Dependent's Name: _____ Last First Address: _____ Number Street City State Zip Code Home Phone () _____ - _____ Cell Phone () _____ - _____
Signature	Member's Signature: _____ Date: _____

Return To: TeamstersCare Schrafft's City Center, 529 Main St, Suite 209, Charlestown, MA 02129

