

Return to: ISG VEBA  
P.O. Box 54581  
Cleveland, OH 44146

1 (888) 251-9494

**ISG Voluntary Employee Beneficiary Association**  
**ENROLLMENT FORM**

**Please complete and return prior to January 31, 2005**

*Note: Eligible retirees must enroll in order to enroll dependent spouse.*

**BENEFICIARY INFORMATION**

NAME: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MONTH DAY YEAR

ENROLLED IN MEDICARE?: YES  NO  MEDICARE ID # \_\_\_\_\_

**SPOUSE AND DEPENDENT INFORMATION**

SPOUSE NAME: \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MONTH DAY YEAR

DATE OF MARRIAGE: \_\_\_\_\_

SPOUSE ENROLLED IN MEDICARE?: YES  NO  MEDICARE ID # \_\_\_\_\_

DEPENDENT CHILD(REN)  Check if you wish to enroll your dependent child(ren)

A Dependent Child Enrollment Form will be mailed to you.

<b>Enrollment Signature</b>	<b>Date</b>

*I apply for enrollment in the ISG VEBA Prescription Drug Program.*

Enclose check payable to "ISG VEBA" for March 2005 contribution

\$25.00 for Retiree or Surviving Spouse  
\$50.00 for Retiree and dependent spouse