

AUTOMOTIVE INDUSTRIES WELFARE FUND

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2026 – PHYSICAL EXAM CERTIFICATION FORM

PARTICIPANT INFORMATION

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER (LAST 4 DIGITS)		
MAILING ADDRESS (STREET OR P.O. BOX)			SEX (M/F)	DATE OF BIRTH	
CITY	STATE	ZIP	MAIN NUMBER () -	MOBILE NUMBER () -	
E-MAIL ADDRESS					
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> DIVORCED	EMPLOYER	DATE OF HIRE			
	OCCUPATION/CLASSIFICATION:	LOCAL #			

INDIVIDUAL RECEIVING PHYSICAL EXAM

RELATION	LAST NAME	FIRST NAME	M.I.	SEX	DATE OF BIRTH
SELF					
<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER**					

Certification of Participant / Dependent Spouse / Domestic Partner

BY SIGNING IN THE AREAS SPECIFIED BELOW, I AM CERTIFYING THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THE PURPOSE OF THIS FORM IS SOLELY FOR THE 2026 PHYSICAL EXAM CERTIFICATION TO REDUCE MY DEDUCTIBLE UNDER THE WELFARE PLAN. THIS FORM CANNOT BE USED FOR ANY OTHER ENROLLMENT PURPOSE, INCLUDING, BUT NOT LIMITED TO: CHANGE OF ADDRESS, CHANGE IN DEPENDENTS, CHANGE IN MARITAL STATUS, OR CHANGE IN MEDICAL PLAN OR SERVICE PROVIDER.

SIGNATURE: _____

DATE: _____

REMINDER: YOU AND YOUR SPOUSE (OR DOMESTIC PARTNER) MUST COMPLETE SEPARATE ANNUAL PHYSICAL EXAM FORMS IN ORDER TO RECEIVE THE LOWER DEDUCTIBLE IN 2027.

THE BELOW SECTION IS TO BE SIGNED BY YOUR MEDICAL PROVIDER.

PHYSICIAN CERTIFICATION

THIS WILL CERTIFY THAT THE BELOW NAMED PARTICIPANT IN THE AUTOMOTIVE INDUSTRIES WELFARE PLAN WAS SEEN IN MY OFFICE AND RECEIVED A ROUTINE PHYSICAL EXAMINATION AND LABORATORY SCREENING.

PATIENT'S NAME: _____ DATE OF EXAM : _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____