EMPLOYMENT PARTNERS BENEFITS FUND

EMPLOYEE INFORMATION

NAME OF EMPLOYER	LOCAL UNION	DATE OF HIRE
LAST NAME	FIRST NAME	MIDDLE INITIAL
BIRTHDATE	SSN	GENDER ☐ FEMALE ☐ MALE
ADDRESS		
CITY	STATE	ZIP
PHONE NUMBER	MARITAL STATUS ☐ SINGLE	☐ MARRIED
EMAIL ADDRESS		

SPOUSE INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL
BIRTHDATE	SSN	GENDER ☐ FEMALE ☐ MALE
MARRIAGE DATE		

CHILD INFORMATION

LAST NAME	FIRST NAME	MIDDLE INIT	BIRTH DATE	SSN	GENDER
					☐ MALE ☐ FEMALE
					☐ MALE ☐ FEMALE
					☐ MALE ☐ FEMALE
					☐ MALE ☐ FEMALE

BENEFICIARY INFORMATION - FOR LIFE INSURANCE

NAME	RELATIONSHIP

SIGNATURE REQUIRED

I certify the accuracy of this information and understand that I must inform the Health and Welfare Fund of any changes.

PARTICIPANT SIGNATURE	DATE