



Laborers Health and Welfare Trust Fund for Northern California
220 Campus Lane, Fairfield, CA 94534-1498 • Telephone: (707) 864-2800 • Toll Free: 1-(800) 244-4530

Dependent Proof of Death

619

STATEMENT OF EMPLOYEE

NAME		SOC. SEC. NO.	
STREET ADDRESS		CITY	STATE ZIP CODE
LOCAL NO.	SIGNATURE	DATE	
INFORMATION ABOUT DECEASED			
NAME			
STREET ADDRESS		CITY	STATE ZIP CODE
RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD			
DATE OF BIRTH		DATE OF DEATH	

IMPORTANT – PLEASE READ BELOW

1. **A certified copy of Death Certificate must accompany this form.**
2. If the deceased is the spouse of the employee, a marriage certificate must also accompany this form.
3. If the deceased is the child of the employee, a birth certificate must also accompany this form.
4. The deceased dependent must be listed on the Enrollment Form in the Fund Office before payment may be made.
5. All questions must be answered completely to avoid delay in processing and ensuring prompt action on the claim.
6. If obtainable, please attach newspaper death notice or obituary.
7. **IF PAYABLE, THE DEATH BENEFIT YOU WILL RECEIVE IS SUBJECT TO FEDERAL AND STATE TAX WITHHOLDING. THE PLAN WILL NOT WITHHOLD ANY TAXES AGAINST THE PAYMENT BUT, IT WILL BE REPORTED TO THE INTERNAL REVENUE SERVICE (IRS) AND CALIFORNIA FRANCHISE TAX BOARD. YOU ALSO MAY WISH TO CONSULT WITH A TAX ADVISOR.**

The furnishing of this form is not an admission of liability by the Laborers Health and Welfare Trust Fund for Northern California nor a waiver of any of its rights or defenses