



**LABORERS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA**  
**LABORERS PENSION TRUST FUND FOR NORTHERN CALIFORNIA**  
 220 Campus Lane, Fairfield, CA 94534-1498  
 Telephone: (707) 864-2800 or Toll-Free at 1-800-244-4530  
 E-Mail Address: customerservice@norcalaborers.org  
 Website: http://www.norcalaborers.org

(19)

## BENEFICIARY ENROLLMENT FORM

**BENEFICIARY INFORMATION (Please print clearly using ink pen)**

SOCIAL SECURITY NUMBER	NAME: FIRST	MIDDLE	LAST
MAILING ADDRESS		CITY	STATE ZIP CODE
DATE OF BIRTH	MONTH / DAY / YEAR	TELEPHONE NO.	E-MAIL ADDRESS, IF ANY
		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	

**DEPENDENT INFORMATION List all eligible dependent children to be enrolled in the Health and Welfare Plan**

**IMPORTANT: Complete this section only if you are eligible for Health and Welfare coverage. DO NOT complete this section if you are applying for Pension benefit only as a beneficiary.**

The term “**Eligible Dependent Children**” means unmarried children under age 19, unmarried children over age 19 who are full-time students and unmarried children who are totally handicapped as explained in the Plan.

The following documents are required (unless you have already provided the Fund Office) for dependent children and must be mailed to the Fund Office with this Form. Write your social security number on each document for identification purposes. Please contact the Fund Office if documents are not available:

**NATURAL CHILD** – Birth Certificate      **ADOPTED CHILD** – Birth Certificate and Legal adoption document  
**STEP-CHILD** – Birth Certificate (To determine eligibility, we will mail you an Affidavit for Stepchild Coverage upon receipt of this Form)

NAME - WRITE FIRST & MIDDLE INITIAL (AND LAST NAME IF DIFFERENT FROM YOURS)	DATE OF BIRTH MONTH / DAY / YEAR	SOCIAL SECURITY NUMBER	DEPENDENT RELATIONSHIP
1.			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER
2.			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER
3.			<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER

**BENEFICIARY STATEMENT**

*I hereby certify under penalty of perjury under the laws of the State of California that the information given in this form is true, correct and complete to the best of my knowledge.*

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

**FUND OFFICE USE ONLY**

DECEASED PENSIONER'S SSN	NAME
--------------------------	------

