

WESTERN TEAMSTERS WELFARE TRUST

Participant Data Form

INSTRUCTIONS:

- Use INK and PRINT all information.
- Participant must complete this in FULL.

RETURN COMPLETED FORM TO:

Western Teamsters Welfare Trust
1010 Acoma St.
Denver, CO 80204
(303) 629-0931

PARTICIPANT'S DATA

Social Security Number	Sex	Date of Birth
Last Name	First Name	Middle Initial
Address (Mailing)	Employer (Company Name)	<input type="checkbox"/> Single <input type="checkbox"/> Married _____ <input type="checkbox"/> Divorced _____
City, State, Zip Code	Home Phone Number	Date of Hire
()	Date of Hire	Union Local Number

DEPENDENT DATA

DEFINITION OF ELIGIBLE DEPENDENTS (LIST ELIGIBLE DEPENDENTS BELOW):

- Your legal spouse
- Your unmarried children less than 19 years old who are financially dependent on you.
- Your unmarried children, age 19 but under 26 years, attending an accredited educational institution as a full-time student.
- Your unmarried children, who are incapable of self-support prior to the limiting age because of mental or physical incapacities.
- Your step-children and legally adopted children provided they depend upon you for support and maintenance.

DEPENDENT NAME (Spouse, Children, Step-Children)		Date of Birth	Relationship	Social Security No.	Sex	Does dependent reside with insured? If no, complete the reverse side of this form.
Last Name	First Name					
		/ /		— —	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /		— —	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
		/ /		— —	Male <input type="checkbox"/> Female <input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Proof of dependent eligibility may be requested; i.e., birth certificate, guardianship letters, marriage certificate, divorce papers, student letters bearing school seal. Use reverse side to name additional family members.

IF DEPENDENT(S) ARE COVERED BY OTHER INSURANCE, COMPLETE BELOW

Dependent Name	Name and Address of Insurance Company	Group or Policy No.
	Name of Insured Person	SSN of Insured Person
Dependent Name	Name and Address of Insurance Company	Group or Policy No.
	Name of Insured Person	SSN of Insured Person

FAILURE TO RETURN A PARTICIPANT DATA FORM TO THE ADMINISTRATIVE OFFICE MAY DELAY THE PROCESSING OF YOUR CLAIMS

With my signature, I hereby certify that the information provided in this Participant Data Form is true and correct.

X _____
PARTIPANT'S SIGNATURE

DATE SIGNED

IF DEPENDENT(S) DO NOT RESIDE WITH INSURED, COMPLETE BELOW

Dependent Name _____ Name of person with whom dependent resides _____ Relationship to dependent _____

Address of the above person (mailing) _____ City, State, Zip _____

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Address of the above person (mailing) _____ City, State, Zip _____

Dependent Name _____ Name of person with whom dependent resides _____ Relationship to dependent _____

Address of the above person (mailing) _____ City, State, Zip _____

ADDITIONAL DEPENDENT DATA

DEPENDENT NAME (Spouse, Children, Step-Children)		Date of Birth	Relationship	Social Security No.	Sex	
Last Name	First Name				Male	Female
		/ /		— —	<input type="checkbox"/>	<input type="checkbox"/>
		/ /		— —	<input type="checkbox"/>	<input type="checkbox"/>
		/ /		— —	<input type="checkbox"/>	<input type="checkbox"/>
		/ /		— —	<input type="checkbox"/>	<input type="checkbox"/>
		/ /		— —	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH AND WELFARE BENEFICIARY INFORMATION

In the space provided below indicate the person or persons you wish to designate as your beneficiary. You may designate any person or persons, including your estate as beneficiary.

I request that any Death Benefits be paid in equal shares to the Beneficiaries I have listed below.

I request that any Death Benefits be paid to the first Beneficiary named below who survives me.

Full Name of Beneficiary _____ SS # _____ Relationship _____ Date of Birth _____

Mailing Address: Street or P.O. Box _____ City, State, Zip _____ Phone Number _____

Full Name of Beneficiary _____ SS # _____ Relationship _____ Date of Birth _____

Mailing Address: Street or P.O. Box _____ City, State, Zip _____ Phone Number _____