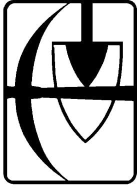

LABORERS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
LABORERS PENSION TRUST FUND FOR NORTHERN CALIFORNIA
LABORERS ANNUITY PLAN FOR NORTHERN CALIFORNIA
220 Campus Lane, Fairfield, CA 94534-1498 * Telephone: (707) 864-2800 or Toll-Free at 1-800-244-4530
E-Mail Address: customerservice@norcalaborers.org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

BENEFICIARY ENROLLMENT FORM

(Doc. 457)

BENEFICIARY INFORMATION (Please print clearly using ink pen)

SOCIAL SECURITY NUMBER	NAME: FIRST	MIDDLE	LAST

PHYSICAL ADDRESS	CITY	STATE	ZIP CODE

MAILING ADDRESS *(IF DIFFERENT FROM ABOVE)*	CITY	STATE	ZIP CODE

DATE OF BIRTH MONTH DAY YEAR / /	GENDER ☐ MALE ☐ FEMALE	HOME PHONE ☎ : CELL PHONE :	E-MAIL ADDRESS, IF ANY

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:

DEPENDENT INFORMATION - 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.

IMPORTANT: Add new or delete previously enrolled "**Dependents**" below. The term "**Dependents**" means your children under age 26 regardless of marital status, and your unmarried children age 26 or older who are totally handicapped as explained in the Plan. Unless documents have been previously provided, you are required to mail the applicable document(s) below to the Trust Fund Office to substantiate your relationship to your dependent(s).
NATURAL – Birth Certificate **ADOPTED CHILD** – Birth Certificate and Legal adoption document
LEGAL GUARDIANSHIP – Guardianship papers or documents from a Court appointing you as the legal guardian
FOSTER CHILD – Proof of foster child placement or custody from a placement agency or a Court appointing you as the foster parent
Write your Social Security number on each of the document(s) for identification purposes.

! IF ANY OF YOUR DEPENDENTS HAVE OTHER GROUP INSURANCE COVERAGE, CHECK THIS BOX ☐.

Add/Delete	Relationship	Name (First, MI, Last)	Date of Birth Month Day Year	Social Security No.
☐ Add ☐ Delete	☐ Son ☐ Daughter		/ /	- -
☐ Add ☐ Delete	☐ Son ☐ Daughter		/ /	- -
☐ Add ☐ Delete	☐ Son ☐ Daughter		/ /	- -

!
- **You will be responsible for any incorrectly paid claims resulting from your failure to notify the Fund Office of changes in dependent status, such as, but not limited to, death, divorce, or loss of legal guardianship.**
- **This form will be returned if you fail to provide the dependent's date of birth and Social Security number.**

FUND OFFICE USE ONLY

DECEASED PENSIONER'S SSN	NAME

Revised 1/1/2014