PARTICIPANT APPLICATION AND BENEFICIARY FORM

CENTRAL PA TEAMSTERS HEALTH & WELFARE FUND
PO BOX 15224, READING, PA 19612-5224

****IMPORTANT**ENTIRE FORM MUST BE COMPLETED**

This form will replace all prior Health and Welfare Application and Beneficiary Forms.

Print Name Below: (Last First Middle)	Social Security No.
	Alternate ID
Address: (Street or PO Box)	Date of Birth
(City State Zip)	Sex M ☐ F ☐

DEPENDENT INFORMATION * Subject to Fund Validation*

LIST ALL ELIGIBLE DEPENDENTS FOR BENEFIT COVERAGE PURPOSES (SPOUSE & CHILDREN)

First	Middle	Last	RELATIONSHIP	SOCIAL SECURITY NO.	BIRTH DATE

SOCIAL SECURITY NUMBER IS REQUIRED FOR ALL DEPENDENTS LISTED

BENEFICIARY INFORMATION

A designated beneficiary must be named below, and participant must sign where indicated)
Complete address information is required for each individual listed

BENEFICIARY: _____ Relationship: _____
Soc.Sec.No.: _____ Birthdate: _____ Primary: _____ Alternate: _____
Beneficiary Address: _____
BENEFICIARY: _____ Relationship: _____
Soc.Sec.No.: _____ Birthdate: _____ Primary: _____ Alternate: _____
Beneficiary Address: _____
BENEFICIARY: _____ Relationship: _____
Soc.Sec.No.: _____ Birthdate: _____ Primary: _____ Alternate: _____
Beneficiary Address: _____
BENEFICIARY: _____ Relationship: _____
Soc.Sec.No.: _____ Birthdate: _____ Primary: _____ Alternate: _____
Beneficiary Address: _____

Participant Signature: _____ Date Signed: _____
Phone Number: _____

THIS FORM IS NOT VALID WITHOUT PARTICIPANT'S SIGNATURE

Rev. 10/30/2003