

**PARTICIPANT APPLICATION AND BENEFICIARY FORM**  
**PLEASE RETURN FORM TO:**  
**CENTRAL PA TEAMSTERS HEALTH & WELFARE FUND**  
**PO BOX 15224, READING, PA 19612-5224**  
 EMAIL : [cashreceiptshw@centralpateamsters.com](mailto:cashreceiptshw@centralpateamsters.com)

**\*\*\*IMPORTANT - ENTIRE FORM MUST BE COMPLETED\*\*\***

**THIS FORM WILL REPLACE ALL PRIOR HEALTH & WELFARE APPLICATION AND BENEFICIARY FORMS.**

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

DEPENDENT INFORMATION \* Subject to Fund Validation\*

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

**SOCIAL SECURITY NUMBER IS REQUIRED FOR ALL DEPENDENTS LISTED**

<u>First</u>	<u>Middle</u>	<u>Last</u>	<u>RELATIONSHIP</u>	<u>SOCIAL SECURITY NO.</u>	<u>BIRTH DATE</u>
_____	_____	_____	_____	_____	____
_____	_____	_____	_____	_____	____
_____	_____	_____	_____	_____	____
_____	_____	_____	_____	_____	____

**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: \_\_\_\_\_

BENEFICIARY: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Soc.Sec.No.: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Primary: \_\_\_\_\_ Alternate: \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**THIS FORM IS NOT VALID WITHOUT PARTICIPANT'S SIGNATURE**