



CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
CEMENT MASONS PENSION TRUST FUND FOR NORTHERN CALIFORNIA
 220 Campus Lane, Fairfield, CA 94534-1499
 Telephone: (707) 864-3300 or Toll-Free at 1-888-245-5005
 E-Mail Address: customerservice@norcalcementmasons.org
 Website: http://www.norcalcementmasons.org

BENEFICIARY ENROLLMENT FORM

(Doc. 407)

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	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	TELEPHONE NO.	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:

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.

DEPENDENT INFORMATION - List all eligible dependents to be enrolled in the Health and Welfare Plan. This form will be returned as incomplete if you fail to provide the dependent's date of birth and Social Security number.

IMPORTANT: List all "Eligible Children" to be enrolled in the Health and Welfare Plan. The term "Eligible Children" means your children under age 26 regardless of marital status, and your unmarried children 26 of age 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 Fund Office to substantiate your relationship to your dependent(s):

NATURAL CHILD – Birth Certificate **STEP OR FOSTER CHILD** – Birth Certificate

ADOPTED CHILD – Birth Certificate and Legal adoption document

Write your social security number on each of the document(s) for identification purposes. Please notify or contact the Fund Office if documents are not available.

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

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

FUND OFFICE USE ONLY

DECEASED PENSIONER'S SSN	NAME
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