



Dependent Information Request Form

Section 1: Participant Information - Complete this section with your information (please print).

Name:		SSN:
Street Address:		Apt #:
City:	State:	Zip Code:
Cell Phone: ()	Home Phone: ()	E-mail:
☐ Please check box if the address indicated above is a new address		

Section 2: Dependent Information - Complete this section with your Dependent's information (please print).

Name	SSN/HICN	Date of Birth	Relationship

Section 3: Participant Signature - Read carefully. Sign and date below.

I hereby certify that the foregoing information is true and complete and I understand that if I have misrepresented or falsified any information, the Trustees have the right to deny all or part of the benefits under the Plan and may recover any benefits erroneously paid as a result of any misrepresentation or false information.

Participant Signature: _____ Date: _____

Return your completed Dependent Information Request form to: