U.A. LOCAL 350 PLUMBERS & PIPEFITTERS
HEALTH, WELFARE, & VACATION TRUST FUND
U.A. LOCAL 350 RETIREMENT FUND

P. O. BOX 11337 - RENO, NEVADA 89510 - (775) 826-7200

☐**NEW ENROLLMENT** ☐**ADDRESS CHANGE** ☐**BENEFICIARY CHANGE** ☐**DEPENDENT CHANGE**

EMPLOYEE LAST NAME | FIRST NAME | MIDDLE INITIAL | MALE/FEMALE

ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY NUMBER | DATE OF BIRTH (MO/DAY/YR) | MARRIED/SINGLE | TELEPHONE # | LOCAL UNION #

HEALTH & WELFARE BENEFITS PAYABLE ON DEATH TO: | RELATIONSHIP

RESIDENCE OF BENEFICIARY: STREET | CITY | STATE | ZIP

ANNUITY PENSION BENEFITS PAYABLE ON DEATH TO: | RELATIONSHIP

RESIDENCE OF BENEFICIARY: STREET | CITY | STATE | ZIP

I HEREBY DESIGNATE, AS CONTINGENT BENEFICIARIES, MY SURVIVING CHILDREN, SHARE AND SHARE ALIKE, OR IF NONE, THEN MY SURVIVING PARENT(S), OR IF NONE, THEN MY SURVIVING BROTHER(S) AND SISTER(S), SHARE AND SHARE ALIKE. IF THIS DESIGNATION IS NOT DESIRED, CHECK HERE: ____

PRINT NAME OF EACH DEPENDENT BELOW (LEGAL SPOUSE AND ALL UNMARRIED CHILDREN).

PROVIDE CERTIFIED COPIES OF *MARRIAGE CERTIFICATE* FOR SPOUSE AND CERTIFIED COPIES OF *BIRTH CERTIFICATE(S)* FOR EACH CHILD.

****DEPENDENTS ARE NOT ELIGIBLE FOR BENEFITS UNTIL THEIR SOCIAL SECURITY CARD IS PROVIDED.**

DEPENDENT'S NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY # REQUIRED	PLEASE ✓ THE RELATIONSHIP: SPOUSE	SON	DTR	STP SON	STP DTR

DO ANY OF THE ABOVE HAVE OTHER INSURANCE INCLUDING MEDICARE, MEDICAID, COBRA, OR GOVERNMENT INSURANCE? YES ( ) NO ( ) IF SO, PLEASE PROVIDE THE NAME OF THE INSURED, THE CARRIER NAME AND ADDRESS, EFFECTIVE DATE, AND TYPE OF INSURANCE (MEDICAL, DENTAL, OR VISION):

MARRIAGE DATE:_____ PLACE:_____

DIVORCE DATE:_____ PLACE:_____

IF DIVORCED, PLEASE PROVIDE A COPY OF YOUR DIVORCE DECREE.

"I HEREBY CERTIFY THAT THE ABOVE INFORMATION REGARDING MY DEPENDENTS AND MARITAL STATUS IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE."

SIGNED: X_____
MEMBER'S SIGNATURE IN FULL DATE