

**TEAMSTERS MISCELLANEOUS SECURITY TRUST FUND
SWA GROUP #108
PARTICIPANT DATA FORM**

P.O. BOX 1121, ALHAMBRA, CA 91802-1121

INSTRUCTIONS:

1. Use **INK** and **PRINT** all information
2. Complete all information below – **IN FULL**
3. **Active members MUST** complete **IN FULL**
4. **Failure to complete this form in full may result in delay of eligibility.**

PARTICIPANT DATA

SOCIAL SECURITY NUMBER	FIRST NAME	MIDDLE INITIAL	LAST NAME
ADDRESS		CITY	STATE ZIP CODE
() HOME TELEPHONE NUMBER	DATE OF BIRTH	SEX: M <input type="checkbox"/> F <input type="checkbox"/>	SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DATE: _____ DIVORCED <input type="checkbox"/> DATE: _____ WIDOW <input type="checkbox"/> DATE: _____
EMPLOYER (COMPANY NAME)	LOCAL UNION NUMBER	DATE OF HIRE	

DEFINITION OF ELIGIBLE DEPENDENTS:

- I. Your legal spouse (if not legally separated).
- II. Your unmarried children less than 19 years old who are financially dependent on you.
- III. Your unmarried children, age 19 but under 23 years, attending an educational institution as a full-time student (12 units).
- IV. Your unmarried children who are incapable of self-support because of mental or physical incapacities **prior** to reaching age 19.
- V. Your step-children and **legally** adopted children if they reside with you.

LIST ELIGIBLE DEPENDENTS BELOW

(Spouse, children, Step-Children)

DEPENDENT RELATIONSHIP (Spouse, Son, Daughter, Stepson, Stepdaughter, etc.)	DEPENDENT DATE OF BIRTH	DEPENDENT SOCIAL SECURITY NUMBER	DEPENDENT NAME FIRST	LAST	SEX: M or F	DOES DEPENDENT RESIDE WITH ABOVE MEMBER?		IS DEPENDENT COVERED BY OTHER INSURANCE?	
						YES	NO	YES	NO

With my signature, I hereby certify that the information provided in this participant data form is true and correct.

EMPLOYEE'S SIGNATURE	DATE SIGNED
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