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. **If you are participating under the single party rate, do not enroll dependents, if any.**
5. **If you are enrolling dependent children, you must enroll all of your eligible children. You may not select only one child.**
6. **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

( ) _____ _____ SEX:
HOME TELEPHONE NUMBER | DATE OF BIRTH | M ☐ F ☐

SINGLE ☐
MARRIED ☐ DATE:_____
DIVORCED ☐ DATE:_____
WIDOW ☐ DATE:_____

_____ _____ _____
EMPLOYER (COMPANY NAME) | LOCAL UNION NUMBER | DATE OF HIRE

Please check the appropriate level of coverage in which you wish to enroll:

1. _____ Member only 2. _____ Member + 1 Dependent 3. _____ Member + 2 or more dependents

If you checked number 2 or number 3, you must complete the Department Enrollment section below.

DEPENDENT ENROLLMENT

Complete the dependent list only if you are enrolling in the two or three + party rates

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.

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? YES	NO	IS DEPENDENT COVERED BY OTHER INSURANCE? 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

Administrative Office Use Only Level 1_____ Level 2_____ Level 3_____

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