CEMENT MASONS HEALTH AND WELFARE TRUST FUND FOR NORTHERN CALIFORNIA
CEMENT MASONS PENSION TRUST FUND FOR NORTHERN CALIFORNIA
4160 Dublin Blvd. Suite 100 Dublin, CA 94568 • Telephone : (707)864-3300 or (888)245-5005(CA only)

BENEFICIARY ENROLLMENT FORM

BENEFICIARY INFORMATION (Please print clearly using ink pen)

SOCIAL SECURITY NUMBER	NAME: FIRST MIDDLE LAST		
PHYSICAL ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS *(IF DIFFERENT FROM ABOVE)*	CITY	STATE	ZIP CODE

DATE OF BIRTH MONTH DAY YEAR / /	GENDER ☐ MALE ☐ FEMALE	HOME PHONE ☎ : CELL PHONE	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:

DEPENDENT INFORMATION - 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.

IMPORTANT: Add "**Eligible Dependents**" or delete previously enrolled dependents below. The term "Eligible Dependents" means your children under age 26 regardless of marital status, and your unmarried children 26 years 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). **Write your Social Security number on each of the document(s) for identification purposes.**

NATURAL – Birth Certificate **ADOPTED CHILD** – Birth Certificate and Legal adoption document
LEGAL GUARDIANSHIP – Guardianship papers or documents from a Court appointing you as the legal guardian

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

Add/Delete	Relationship	Name (First, MI, Last)	Date of Birth Month Day Year	Social Security No.
☐ Add ☐ Delete	☐ Son ☐ Daughter		/ /	- -
☐ Add ☐ Delete	☐ Son ☐ Daughter		/ /	- -
☐ Add ☐ Delete	☐ Son ☐ Daughter		/ /	- -

❗ **• You will be responsible for any incorrectly paid claims resulting from your failure to notify the Fund Office of changes in dependent status, such as, but not limited to, death, divorce, or loss of legal guardianship.**
• This form will be returned if you fail to provide the dependent's date of birth and Social Security number.

FUND OFFICE USE ONLY

DECEASED PENSIONER'S SSN	NAME
XXX-XX-	