

**PARTICIPANT APPLICATION AND BENEFICIARY FORM  
CENTRAL PA TEAMSTERS HEALTH & WELFARE FUND  
PO BOX 15224, READING, PA 19612-5224**

**\*\*IMPORTANT\*\*ENTIRE FORM MUST BE COMPLETED**

This form will replace all prior Health and Welfare Application and Beneficiary Forms.

Print Name Below: (Last	First	Middle)	Social Security No.
			Alternate ID
Address:	(Street or PO Box)		Date of Birth
(City	State	Zip)	Sex M <input type="checkbox"/> F <input type="checkbox"/>

**DEPENDENT INFORMATION \* Subject to Fund Validation\***

LIST ALL ELIGIBLE DEPENDENTS FOR BENEFIT COVERAGE PURPOSES (SPOUSE & CHILDREN)

First	Middle	Last	RELATIONSHIP	SOCIAL SECURITY NO.	BIRTH DATE
_____	_____	_____	_____	_____	____-____-____
_____	_____	_____	_____	_____	____-____-____
_____	_____	_____	_____	_____	____-____-____
_____	_____	_____	_____	_____	____-____-____

**SOCIAL SECURITY NUMBER IS REQUIRED FOR ALL DEPENDENTS LISTED**

**BENEFICIARY INFORMATION**

A designated beneficiary must be named below, and participant must sign where indicated)

Complete address information is required for each individual listed

BENEFICIARY: \_\_\_\_\_ Relationship: \_\_\_\_\_

Soc.Sec.No.: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Primary: \_\_\_\_\_ Alternate: \_\_\_\_\_

Beneficiary Address: \_\_\_\_\_

BENEFICIARY: \_\_\_\_\_ Relationship: \_\_\_\_\_

Soc.Sec.No.: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Primary: \_\_\_\_\_ Alternate: \_\_\_\_\_

Beneficiary Address: \_\_\_\_\_

BENEFICIARY: \_\_\_\_\_ Relationship: \_\_\_\_\_

Soc.Sec.No.: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Primary: \_\_\_\_\_ Alternate: \_\_\_\_\_

Beneficiary Address: \_\_\_\_\_

BENEFICIARY: \_\_\_\_\_ Relationship: \_\_\_\_\_

Soc.Sec.No.: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Primary: \_\_\_\_\_ Alternate: \_\_\_\_\_

Beneficiary Address: \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**THIS FORM IS NOT VALID WITHOUT PARTICIPANT'S SIGNATURE**