

TRUCKING EMPLOYEES OF NORTH JERSEY BENEFIT FUNDS

CENSUS FORM

IMPORTANT: NO BENEFITS WILL BE PAID UNLESS THIS FORM IS FULLY & PROPERLY COMPLETED, SIGNED & RETURNED TO THE FUND OFFICE
Please Print

Social Security Number	First Name	Middle Initial	Last Name		
Street Address		Apt. #	City		State Zip Code
Home Telephone #	Cellphone #	Employer			Date of Hire Local Union #
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Employment Status:		If laid off or terminated			
<input type="checkbox"/> Active <input type="checkbox"/> Laid off <input type="checkbox"/> Terminated		date of lay off or termination			
Name & Address of Spouse's Employer					
Does Spouse have medical coverage where he/she works?					
<input type="checkbox"/> Yes <input type="checkbox"/> No					

DEPENDENTS

Complete the information listed below for your spouse and all children under the Age of 26

The Fund requires a copy of your marriage certificate and dependents birth certificates. Benefits may be pended until this information is received.

First Name	Initial	Last Name	Social Security Number	Relation	Date of Birth

LIFE INSURANCE BENEFICIARY

I revoke all previous beneficiary designations and make the following nomination of beneficiary with respect to all pension and/or welfare benefits provided now or in the future under the rules of the Fund still reserving to myself the privilege of making future changes subject to Fund rules and procedures. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries as survive me, unless otherwise stipulated herein. If no beneficiary survives me, settlement will be made as provided by the rules of the Fund and applicable law.

Social Security #	First Name	Last Name			
Address		Apt. #	City		State Zip Code
Relationship to You				Date of Birth	
Social Security #	First Name	Last Name			
Address		Apt. #	City		State Zip code
Relationship to You				Date of Birth	

Check & use reverse side for additional beneficiaries.

CERTIFICATION: I hereby certify that I have read the above information and that the information herein is true to the best of my knowledge.

Employee's Signature: _____ Date: _____

MAIL TO: TEAMSTERS LOCAL 560 BENEFIT FUNDS, 707 SUMMIT AVENUE, UNION CITY, NJ 07087-1737

For Office Use Only

INPUT BY: _____ DATE: _____