

# NORTHERN NEVADA OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND

P. O. BOX 11337 - RENO, NEVADA 89510 - (775) 826-7200

NEW ENROLLMENT     ADDRESS CHANGE     BENEFICIARY CHANGE     DEPENDENT CHANGE

\_\_\_\_\_  
 EMPLOYEE LAST NAME    FIRST NAME    MIDDLE INITIAL    MALE/FEMALE

\_\_\_\_\_  
 ADDRESS    CITY    STATE    ZIP

\_\_\_\_\_  
 SOCIAL SECURITY NUMBER    DATE OF BIRTH (MO/DAY/YR)    MARRIED/SINGLE    TELEPHONE #    LOCAL UNION #

\_\_\_\_\_  
 HEALTH & WELFARE BENEFITS PAYABLE ON DEATH TO:    RELATIONSHIP

\_\_\_\_\_  
 RESIDENCE OF BENEFICIARY:    STREET    CITY    STATE    ZIP

I HEREBY DESIGNATE, AS CONTINGENT BENEFICIARIES, MY SURVIVING CHILDREN, SHARE AND SHARE ALIKE, OR IF NONE, THEN MY SURVIVING PARENT(S), OR IF NONE, THEN MY SURVIVING BROTHER(S) AND SISTER(S), SHARE AND SHARE ALIKE.

IF THIS DESIGNATION IS NOT DESIRED, CHECK HERE: \_\_\_\_\_

**PRINT NAME OF EACH DEPENDENT BELOW (LEGAL SPOUSE AND ALL UNMARRIED CHILDREN).**

**PROVIDE CERTIFIED COPIES OF MARRIAGE CERTIFICATE FOR SPOUSE AND CERTIFIED COPIES OF BIRTH CERTIFICATE(S) FOR EACH CHILD.**

\*\*DEPENDENTS ARE NOT ELIGIBLE FOR BENEFITS UNTIL THEIR SOCIAL SECURITY NUMBER IS PROVIDED.

DEPENDENT'S NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH MO/DAY/YR	SOCIAL SECURITY # REQUIRED	PLEASE ✓ THE RELATIONSHIP:				
			SPOUSE	SON	DTR	STP SON	STP DTR


MARRIAGE DATE: \_\_\_\_\_ PLACE: \_\_\_\_\_

DIVORCE DATE: \_\_\_\_\_ PLACE: \_\_\_\_\_

IF DIVORCED, PLEASE PROVIDE A COPY OF YOUR DIVORCE DECREE.

**"I HEREBY CERTIFY THAT THE ABOVE INFORMATION REGARDING MY DEPENDENTS AND MARITAL STATUS IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE."**

**SIGNED: X** \_\_\_\_\_  
                                     SIGNATURE IN FULL    DATE