
Administered By: Benefit Programs Administration
Telephone (833) 504-3967 (213) 406-2380 Facsimile (562) 463-5894

## PARTICIPANT DATA FORM

Plan Participant Name: _____

Address: _____

_____

Daytime Phone #: _____ E-mail Address: _____

Date of Birth: _____ Social Security #: _____

Employee #: _____ Date of Employment (hire date): _____

Anticipated Date of Retirement or Actual Date if already Retired: _____

Spouse: _____

Date of Birth: _____ Date of Marriage: _____

Social Security #_____

Dependent Information:

Name: _____ Relationship: _____

Date of Birth: _____ Social Security #_____

Name: _____ Relationship: _____

Date of Birth: _____ Social Security #_____

Name: _____ Relationship: _____

Date of Birth: _____ Social Security #_____

I certify under penalty of perjury that the foregoing is true and correct. I understand that the Trust may pursue legal and equitable remedies against me for any false, fraudulent or misleading information provided.

_____ _____

Participant's Signature Date