



Mail: P.O. Box 4100 · Concord, CA 94524-4100
 Telephone: (800) 552-2400 · Facsimile: (925) 746-7549
 www.ufcwtrust.com

BENEFITS REGISTRATION FORM

PLEASE PRINT CLEARLY

Member's Personal Information		
First Name:	Last Name:	Last 4 Digits of SSN:
Date of Birth: ____/____/____ Month Day Year	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Current Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>
Complete Contact Information		
Street Address or PO Box:		Apartment or Suite #:
City:	State:	Zip Code:
Home Phone Number: () ()	Mobile Phone Number: () ()	Email Address:
Employer	Union Local #	Date of Hire
Signature - <i>Must be signed by Member or Legal Representative:</i>		Date:

This form does not enroll you in any benefits. Benefit enrollment information will be provided to you separately. The information provided on this form is intended for UFCW & Employers Trust, LLC records. If applicable, the information will be used to provide you with health and/or pension related benefit information.

Please send the completed and signed form to:

UFCW & Employers Trust, LLC
Attention: Address Unit
P.O. Box 4100
Concord, CA 94524-4100

The information you provide UFCW & Employers Trust, LLC on this form will be shared with the benefit funds in which you participate and which are administered by UFCW & Employers Trust, LLC, in order to ensure communications for all Funds continue to reach you.

