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 ☐ Female ☐	**Current Marital Status:** Single ☐ Married ☐ Divorced ☐ Widowed ☐

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 - *Must be signed by Member or Legal Representative:*			**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.