OPERATING ENGINEERS' LOCAL NO. 428 HEALTH & WELFARE TRUST FUND
2001 West Camelback Road #350
Mailing Address: P.O. Box 16200 ~ Phoenix, Arizona 85011-6200
(602) 650-8161
FAX – (602) 325-3616

ENROLLMENT FORM

PLEASE PRINT ALL INFORMATION

Last Name	First Name In Full	Middle Initial

Home address	City	State	Zip Code	Telephone Number

EMAIL ADDRESS:

Social Security Number	Local Union No.	Sex (circle one)
		M F

Date Of Birth			Married	Single
Month	Day	Year		

Death Benefit To Be Paid To (Full Name)	Relationship

Residence of Beneficiary

Street	City or Town	State	Zip

LIST BELOW NAMES OF YOUR SPOUSE AND DEPENDENT CHILDREN

List Names In Order of Age Eldest First	Social Security Number	Relation	Date of Birth		
			Month	Day	Year

SIGNATURE (Participant Must Sign) ***Date Signed***

In order for us to enroll you into the plan, we will need you to complete and sign the enrollment and claim form. In addition to these forms we will need copies of your certified Marriage Certificate and certified Birth Certificates of your children, if applicable, to enroll your family.