Eighth District Electrical Fringe Benefit Funds

APPLICATION FOR DEPENDENT DEATH BENEFITS

As legal beneficiary of _____, a participant who died on _____, I hereby make application for any Death benefit which may be payable under the Health Care Fund because of their participation thereunder.

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Personal Information Regarding Deceased Participant

Full Name _____ Social Security # _____

Home Address _____

Date of Birth _____

_____ Spouse ($2000.00)
_____ Dependent child under 6 months ($1000.00)
_____Dependent child 6 months to age 26 ($2000.00)

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Beneficiary Information

Full Name _____ Social Security #_____

Home Address _____

Relationship to Deceased _____Phone # _____

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I hereby certify that the above information is, to the best of my belief and knowledge, true and complete. Before final action is taken on this application, I understand it will be necessary for me to provide the Trust Fund with a Certified Death certificate along with any other necessary documentation as listed on the attached form. I also understand that completion of this application does not guarantee that I am entitled to a benefit from this Fund.

_____ _____
Signature of Beneficiary Date

Physical Address: 4704 Harlan Street, Suite 104 • Denver, CO 80212
Physical Address: 5295 South Commerce Drive, Suite 220 • Murray, UT 84107
Mailing Address: P.O. Box 30751 • Salt Lake City, UT 84130
Toll Free: 844-989-2321
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