

Teamsters Local 641 Welfare Fund

714 Rahway Avenue, 2nd Floor, Union, NJ 07083
 Telephone: (908)687-4488
 Fax: (908)687-8368
 www.641funds.org

Check here if change of address only.

Census Form

Important: No Benefits Will Be Paid Unless This Form is Fully and Properly Completed, Signed and Returned to the Fund Office.

PLEASE PRINT BELOW:

Social Security Number	First Name	Middle Initial	Last Name
ADDRESS: Number and Street		Apt. No.	City
State	Zip		
Phone Number Area ()	Employer Name	Address	
Birth Date: Mo. / Day / Yr.	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired	If Retired, Name & Address of your present employer:		
Name and Address of Spouse's Employer:			
Does spouse have medical coverage where he/she works? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check type of coverage(s) <input type="checkbox"/> Basic <input type="checkbox"/> Major Medical <input type="checkbox"/> Dental <input type="checkbox"/> RX			

DEPENDENTS

MUST ATTACH MARRIAGE CERTIFICATE AND BIRTH CERTIFICATE(S) THAT SHOWS **BOTH PARENTS' NAMES**

First Name	Initial	Last Name	Address	Sex M or F	Relation	Date of Birth
					<input type="checkbox"/> Spouse	
					<input type="checkbox"/> Son	
					<input type="checkbox"/> Daughter	
					<input type="checkbox"/> Son	
					<input type="checkbox"/> Daughter	
					<input type="checkbox"/> Son	
					<input type="checkbox"/> Daughter	
					<input type="checkbox"/> Son	
					<input type="checkbox"/> Daughter	

BENEFICIARY INFORMATION

Social Security Number	First Name	Last Name
ADDRESS: Number and Street		Apt. No.
City		State
Zip		
Relationship to You (Son, Daughter, Nephew, etc.)		Beneficiary's Date of Birth / /

Note any additional information on reverse side.

I hereby certify that the above statements are true and that false statements will disqualify me for benefits.

EMPLOYEE'S SIGNATURE _____

DATE _____

