Administered By:
Benefit Programs Administration
Phone: (888) 806-8944
(213) 406-2350
Fax: (562) 463-5894
Email:
burbankcity@bpabenefits.com
Website: www.bermt.com

PARTICIPANT DATA FORM

Plan Participant Name: ____

Address: ____

____

Daytime Phone#: ________________________ Email Address: _______________________________

Date of Birth: __________________________ Social Security No. ____________________________

Participating Employer/Bargaining Unit: ____

Date of Employment: ____
(with participating employer above)

If applicable.
Date of Retirement or Separation of Employment: ____
(with participating employer above)

Spouse: __________________________________ Social Security No. ________________________

Date of Birth: ________________________ Date of Marriage: __________________________

Domestic Partner: _____________________ Social Security No. ________________________

Date of Birth: _________________________

Dependent Information:

Name: ___________________________________ Relationship: ______________________________

Date of Birth: ______________________________ Social Security No. ___________________________

Name: ___________________________________ Relationship: ______________________________

Date of Birth: ______________________________ Social Security No. ___________________________

Name: ___________________________________ Relationship: ______________________________

Date of Birth: ______________________________ Social Security No. ___________________________

I certify under penalty of perjury that the foregoing is true and correct. I understand that the Trust may pursue legal and equitable remedies against me for any false, fraudulent or misleading information provided.

____ ___________________________
Participant's Signature Date