BURBANK EMPLOYEES RETIREE MEDICAL TRUST

Administered By: Benefit Programs Administration
Telephone (888) 806-8944 (213) 406-2350 Facsimile (562) 463-5894

PARTICIPANT DATA FORM

Plan Participant Name: ______________________________

Address: ______________________________

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Daytime Phone #: ______________ E-mail Address: ______________

Date of Birth: ______________

Participating Employer / Bargaining Unit : ______________________________

Date of Employment: ______________
(with participating employer above)

If applicable,

Date of Retirement or Termination of Employment: ______________
(with participating employer above)

Spouse: ______________________________

Date of Birth: ______________ Date of Marriage: ______________

Domestic Partner: ______________________________

Date of Birth: ______________

Dependent Information:

Name: ______________ Relationship: ______________

Date of Birth: ______________

Name: ______________ Relationship: ______________

Date of Birth: ______________

Name: ______________ Relationship: ______________

Date of Birth: ______________

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