Mahoning Trumbull Trust Funds
3660 Stutz Drive, Ste 101
Canfield, OH 44406
(330) 779-8861
www.mahoningtrumbullbenefits.org

VITAL INFORMATION FORM

Last: _____ First: _____ Middle: _____
Address/City/State/Zip_____
Social Security Number: _____-_____-_____ Date of Birth:____/_____/_____ Gender :(*circle one*) Male Female

Marital Status: *(circle one)* Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: _____

Current Status: *(circle one)* Active Retired Disabled COBRA

Telephone Number: (_____) _____Alternate Phone Number: (_____) _____
Email Address: _____
Employer_____ Date of Hire: _____

Medicare Claim Number: (including the letter(s) that follows the number)
(This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)

Member # _____ **Spouse #** _____ **Dependent # and Name** _____

DEPENDENTS: - Include Spouse (Marriage/Birth Certificates are needed to add any new dependents to the plan).

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

BENEFICIARY INFORMATION:

NAME	RELATION	BIRTHDAY	S.S. #	ADDRESS/CITY/STATE/ZIP
(Primary)				
(Secondary)				

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

_____ _____
MEMBER SIGNATURE **Date**

(OVER)