Southern California IBEW-NECA Health Trust Fund
6023 Garfield Avenue
City of Commerce, California 90040
Mailing Address: P.O. Box 910918, Los Angeles, CA 90091
(323) 221-5861 or (800) 824-6935 (Nationwide)

INFORMATION REQUEST FORM 2013

www.scibew-neca.org
Fax No. (323) 726-3520

At the direction of the Trustees of the Southern California IBEW-NECA Health, Pension and Defined Contribution Funds, the Administrative Trust Funds Office is gathering information for participants. Please complete and return the questionnaire to the Administrative Trust Funds Office.

PARTICIPANT INFORMATION

Last Name	First Name	M.I.	Social Security Number				-			-				

Is there a language, other than English, that is your language of choice?:	No ☐	Yes ☐ Language: _____	Decline to respond ☐
For your spouse or Domestic Partner, is there a language, other than English, that is the language of choice?:	No ☐	Yes ☐ Language: _____	Decline to respond ☐

FAMILY INFORMATION REVIEW:
List all dependents eligible under the Southern California IBEW-NECA Health Plan

Relationship (Check Box)	Last Name	First Name	MI	Date of Birth	Social Security Number
☐ Wife ☐ Husband ☐ DP- Female ☐ DP- Male					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					
☐ Son ☐ Daughter					

Thank you for completing the Information Request Form. The information submitted with this form will not be used to add or drop a participant and/or dependents. Please refer to the Summary Plan Description for the process of adding/dropping a dependent. This form will be posted on the Trust Funds' website, where you may find other helpful information and forms, at www.scibew-neca.org.