Administered by:
Delta Fund Administrators
PO Box 2487
Stockton, CA 95201

Phone: (800) 700-6762
Fax: (209) 940-5255
E-mail: RMT@deltafund.com
Website: www.ccebttrust.com

PARTICIPANT DATA FORM

Plan Participant Name: _____

Address: _____

_____

Daytime Phone #: _____ E-mail Address: _____

Date of Birth: _____ Gender: M F

Social Security Number: _____

Participating Employer / Bargaining Unit: _____

Date of Employment (Full Time): _____

Date of Employment (Part Time): _____

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: _____

*Only children under age 26 and disabled dependent children can receive benefits from the Plan

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