

IATSE LOCAL 12 HEALTH AND WELFARE FUND

P.O. Box 362
Columbus, Ohio 43216-0362

Office Use Only

Document #: _____

Date Rvd: _____

Member Census Data Form

MEMBER'S INFORMATION:

Member's Name: First M.I. Last

Social Security Number: Date of Birth:

Address: Daytime Telephone No.

City: State Zip Code Evening Telephone No.

***DEPENDENT INFORMATION: (Spouse, and/ or Qualifying Children)**

Spouse's Name: First M.I. Last

Social Security Number: Date of Birth:

Children:	SSN:	Date Of Birth:
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	/ /	/ /
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	/ /	/ /
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	/ /	/ /

Member Signature _____

Date _____