Administered By:
Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
Phone: (800) 828-0223
Email: santamonicacity@bpabenefits.com

Santa Monica City Employees Coalition Benefit Trust

SMCECBT

PARTICIPANT DATA FORM

Plan Participant Name: _____

Address: _____

_____

Daytime Phone #: _____ E-mail Address: _____

Date of Birth: _____ Social Security Number: _____

Participating Employer / Bargaining Unit: _____

Date of Employment (hire date) with the City of Santa Monica: _____

Anticipated Date of Retirement or Actual Date if already Retired: _____

Spouse: _____

Date of Birth: _____ Date of Marriage: _____

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