



**National Roofers Union
& Employers Joint
Health & Welfare Fund**

NATIONAL ROOFERS HEALTH & WELFARE FUND

APPLICATION FOR DEPENDENT DEATH BENEFIT

The furnishing of this form is not an admission of liability by this Trust nor a waiver of any rights or defenses.

A CERTIFIED COPY OF THE DEATH CERTIFICATE MUST ACCOMPANY THIS FORM.

TO BE COMPLETED BY MEMBER

Name of Employee:

Member ID or SS#:

Local Union #:

Address of Employee:

City:

State:

ZIP:

INFORMATION REGARDING DECEASED DEPENDENT

Name of Deceased:

Date of Birth:

Date of Death:

Cause of Death:

CERTIFICATION

I certify that the information provided on this application is true and correct to the best of my knowledge.

Date:

Employee Signature:

Check if certified death certificate attached:

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PLEASE RETURN THE COMPLETED FORM AND DEATH CERTIFICATE TO:

National Roofers Health & Welfare Fund
3001 Metro Drive - Suite 500
Bloomington, MN 55425