HPTA BENEFIT TRUST
INFORMATION UPDATE FORM

Member's Name: _____
Social Security # _____- _____- _____

Please make changes to the following:

☐ New Address: _____
_____
_____

☐ New Phone: _____

☐ Add/Remove Spouse:
Name: _____
DOB: _____

☐ Add/Remove Child:
Name: _____
DOB: _____

☐ Change of Beneficiary for Life Insurance:
Name: _____

Please sign and date.

_____ _____
Signature Date

*Any questions, please call HPTA Benefit Trust at 229-2617

Mail Completed Form To:
HPTA Benefit Trust
PO Box 492
Hyde Park, NY 12538