



SELF-PAY REMITTANCE FORM
SIGN PICTORIAL & DISPLAY INDUSTRY
WELFARE FUND

P.O. Box 2500
San Francisco, CA 94126
tel: (415) 986-6276
fax: (415) 439-5858

PARTICIPANT INFORMATION

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER
MAILING ADDRESS (STREET OR P.O. BOX)			
CITY			STATE
			ZIP
TELEPHONE NUMBER	EMAIL ADDRESS		TODAY'S DATE

EMPLOYMENT CLASSIFICATION

Installer

Shop

Enclosed is my self-payment for coverage in the month of (circle one):

APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER
OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH

I understand that I must have worked the minimum hours required (90 hours for Shop employees, 60 hours for Installers) in the corresponding work month in order to be eligible to make a self-payment. My self-payment must be received by the Administration Office in the month prior to the coverage month.

Amount enclosed: \$ _____

Signature _____

INTERNAL OFFICE USE ONLY
