(PLEASE TYPEWRITE
OR PRINT)

-- REMITTANCE REPORT --

U.A. LOCAL 73 HEALTH & WELFARE FUND

P.O. Box 911 Oswego, N.Y. 13126

Phone (315) 343-1808 FAX (315) 343-4184

FOR PERIOD STARTING ________________ ENDING ____________

NAME OF EMPLOYEE	S.S. Number	No. of Hrs. Worked	Date of Start or End of Employment

☐ If more forms are needed, check here

Welfare Fund _____ an hour _____ amount of check enclosed.

Total Hours

Total

Submitted By

____
Name of Employer

____
Street Address

____
City *State* *Zip*

____
Signed by *Title*

The original remittance form must be submitted to this office <u>on or before the 10th of the following month for which payment is due.</u>
Remittance must be made by check to the OSWEGO LOCAL 73 INSURANCE FUND.