(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 on or before the 10th of the following month for which payment is due.
Remittance must be made by check to the OSWEGO LOCAL 73 INSURANCE FUND.