# IBEW LOCAL 595 TRUST FUNDS

## BENEFICIARY FORM FOR HEALTH AND WELFARE PLAN

EMPLOYEE LAST NAME: _____ FIRST NAME: _____ MIDDLE NAME: _____

SOCIAL SECURITY NO: _____ DATE OF BIRTH: _____ PHONE NUMBER: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CURRENT MARITAL STATUS (PLEASE CHECK ONE): ☐ MARRIED ☐ NEVER MARRIED ☐ DIVORCED ☐ DIVORCED & REMARRIED ☐ WIDOW(ER)

SPOUSE'S NAME (IF LEGALLY MARRIED): _____ DATE OF MARRIAGE: _____

SPOUSE'S SOCIAL SECURITY NO: _____ IF DIVORCED OR SEPARATED, GIVE DATE: _____

LIST FIRST NAMES AND DATES OF BIRTH FOR ALL DEPENDENT CHILDREN: _____

LIST ANY OTHER DEPENDENTS AND RELATIONSHIPS: _____

**EXPLANATION REGARDING DESIGNATION OF BENEFICIARY**

You may designate any individual or individuals as your beneficiary. Also, you may designate the same person to receive all types of benefits named on the lower portion of this form, or different persons to receive each of them. If you list more than one beneficiary, they shall share equally in the applicable benefits. You also may designate a contingent beneficiary to receive benefits if your primary beneficiary(ies) should die. If you do not designate anybody, then applicable benefits will be payable as provided under the Plan.

**BE SURE TO COMPLETE THE ENTIRE FORM AND RETURN TO THE TRUST OFFICE.**

**BENEFICIARY DESIGNATION**

I, _____, Social Security No. _____ do hereby designate the following named person or persons as my beneficiary or beneficiaries to receive any monies that may be payable by reason of my death, under the IBEW Local 595 Health and Welfare Plan. Pay any life insurance and accidental death and dismemberment benefits, if applicable to:

PRINT NAME OF BENEFICIARY: _____ SOCIAL SECURITY NO. _____ RELATIONSHIP: _____

ADDRESS: _____ DATE OF BIRTH: _____

PRINT NAME OF BENEFICIARY: _____ SOCIAL SECURITY NO. _____ RELATIONSHIP: _____

ADDRESS: _____ DATE OF BIRTH: _____

CONTINGENT BENEFICIARY: _____ SOCIAL SECURITY NO. _____ RELATIONSHIP: _____

**Date** _____ **Signature:** _____

THE INFORMATION REQUESTED ON THIS CARD MUST BE COMPLETE AND BE ON FILE WITH THE FUND'S ADMINISTRATOR PRIOR TO YOUR DEATH OR INJURY