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IBEW HEALTH & WELFARE TRUST OF SOUTHWEST WASHINGTON

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BENEFICIARY DESIGNATION FOR LIFE INSURANCE FORM

Participant INFORMATION			
Participant Name		**Employer Name**	
	☐ M ☐ F		
Social Security Number		**Date of Birth**	**Effective Date**

BENEFICIARY DESIGNATION FOR LIFE INSURANCE			
		☐ M ☐ F	
Primary Beneficiary Name	**Date of Birth**	**Sex**	**Social Security Number**
Beneficiary Address		**Relationship to You**	**Benefit %**
		☐ M ☐ F	
Primary Beneficiary Name	**Date of Birth**	**Sex**	**Social Security Number**
Beneficiary Address		**Relationship to You**	**Benefit %**
If Primary Beneficiary(ies) dies before you, the benefit will be paid to your Contingent Beneficiary(ies).			
		☐ M ☐ F	
Contingent Beneficiary Name	**Date of Birth**	**Sex**	**Social Security Number**
Beneficiary Address		**Relationship to You**	**Benefit %**
		☐ M ☐ F	
Contingent Beneficiary Name	**Date of Birth**	**Sex**	**Social Security Number**
Beneficiary Address		**Relationship to You**	**Benefit %**

REQUIRED SIGNATURE

I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. The changes on this form supersede all previous forms submitted.

Sign Here →

_____ _____ _____

Participant's Signature *Print Name* *Date*