

CHANGE FORM
UNION CONSTRUCTION WORKERS HEALTH PLAN
and
UNION LABOR LIFE INSURANCE COMPANY

PLEASE PRINT OR TYPE

Address Change: _____ Yes _____ No

Beneficiary Change: _____ Yes _____ No

Employee _____

Social Security Number _____

Employee Address

City

State

Zip Code

Beneficiary Provisions

Change Beneficiary – I revoke all designations of beneficiary and all elections of optional settlement methods previously made by me; and subject to the terms of, and subject to change as provided in the applicable contracts, I designate the beneficiary indicated below. The prior designation has been deleted.

If this Designation of beneficiary provides for payment to a trustee under a trust agreement, the Insurance Company shall not be obligated to inquire into the terms of the trust agreement and shall not be charged with knowledge of the terms thereof. Payment to and receipt by the trustees shall fully discharge all liability of said Insurance Company to the extent of such payment.

More Than One Beneficiary – You may designate more than one beneficiary by attaching a separate signed notarized Beneficiary Designation Statement to this form which gives the names, social security numbers, birth dates and percentage of life insurance benefits to be paid to each named beneficiary. This form must indicate “See Attached Form” in the Change Beneficiary part. Contact Fund Office with questions.

Change Beneficiary to: _____ Group Contract No. G-8231

First Name Last Name Relationship Social Security No. of Beneficiary Date of Birth

I request my Beneficiary and/or address be changed as checked by me above. Please have this form witnessed by someone other than your named beneficiary.

Effective Date of Change: _____

Date Signed _____ Employee Signature _____

Witness Signature _____

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