Reset Form

Local 434 Health & Welfare Fund
BENEFICIARY DESIGNATION FORM

I hereby direct that, in the event of my death, any death benefits due under the Plan be paid to the Primary Beneficiary(ies) named below, or if no Primary Beneficiary survives me, to the Secondary Beneficiary(ies) named below. I also revoke any and all prior beneficiary designations made by me relative to the Plan and reserve the right to revoke or change this designation at any time. This designation shall become effective upon its receipt by the Administrative Office (Wilson-McShane Corporation, 3001 Metro Drive – Suite 500, Bloomington, MN 55425) until replaced by a later designation.

PLEASE PRINT:

PRIMARY BENEFICIARY(IES):	
NAME:	Relationship:
Social Security No.:	% of Benefit to This Beneficiary:
Mailing Address, City, State, Zip	
NAME:	Relationship:
Social Security No.:	% of Benefit to This Beneficiary:
Mailing Address, City, State, Zip	

SECONDARY BENEFICIARY(IES):	
NAME:	Relationship:
Social Security No.:	% of Benefit to This Beneficiary:
Mailing Address, City, State, Zip	
NAME:	Relationship:
Social Security No.:	% of Benefit to This Beneficiary:
Mailing Address, City, State, Zip	

Participant's Signature:	**Participant's** Social Security No.:
PRINT Participant's Name:	Date: