# I.B.E.W. LOCAL 25 HEALTH & BENEFIT FUND

372 Vanderbilt Motor Parkway
Hauppauge, NY 11788-5133
631-434-3344

## BENEFICIARY DESIGNATION FORM

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box)*

I hereby revoke any previous beneficiary designation(s), if any, for my death benefits provided by the I.B.E.W. Local 25 Health & Benefit Fund, if any, payable as indicated on the following page.

Participant's Name ..... S.S #.....

Address .....

..... Tel. Number …….....

**DESIGNATION OF BENEFICIARY/BENEFICIARIES:**

It is important that your beneficiary designation be clear, so that there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary/beneficiaries, please indicate his/her/their full name(s), address(es), social security number(s) and relationship to you. If the beneficiary is not related either by blood or marriage, write "Not Related." Please note that if you are designating more than one beneficiary or contingent beneficiary, the sum of the percentages to which they are entitled cannot exceed 100%.

I hereby designate the individual(s) named on the second page of this form as my named beneficiary/beneficiaries*:

**Date** _____ **Signature of Participant** _____

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STATE OF )
) ss.:
COUNTY OF )

On this __ day of _____, 20__ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the foregoing and acknowledged to me that (s)he executed the same in his/her capacity.

_____

**NOTARY PUBLIC**

(Seal)

## I.B.E.W. LOCAL 25 HEALTH & BENEFIT FUND

### PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth:_____

Address: _____ Social Security Number: _____

_____ Relationship:_____

Benefit Percentage: _____

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Name: _____ Date of Birth:_____

Address: _____ Social Security Number: _____

_____ Relationship:_____

Benefit Percentage:_____

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Name: _____ Date of Birth:_____

Address: _____ Social Security Number: _____

_____ Relationship:_____

Benefit Percentage:_____

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### CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth:_____

Address: _____ Social Security Number: _____

_____ Relationship:_____

Benefit Percentage: _____

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Name: _____ Date of Birth:_____

Address: _____ Social Security Number: _____

_____ Relationship:_____

Benefit Percentage:_____

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Name: _____ Date of Birth:_____

Address: _____ Social Security Number: _____

_____ Relationship:_____

Benefit Percentage:_____