IATSE NATIONAL BENEFIT FUNDS

FROM: **Benefit Fund Participant**

TO: **IATSE National Health and Welfare Fund - Board of Trustees**

RE: **Designation of Beneficiary**

Name: _____

Address: _____

_____

Soc. Sec. #.: _____

Date of Birth: _____

In accordance with the provisions of the Rules and Regulations of the IATSE National Health and Welfare Fund, I hereby designate as my:

PRIMARY BENEFICIARY(IES):

Name: _____

Address: _____

Soc. Sec. #/Telephone No.: _____
Date of Birth/Relationship: _____
If Spouse-Date of Marriage: _____
Name: _____

Address: _____

Soc. Sec. #/Telephone No.: _____
Date of Birth/Relationship: _____
If Spouse-Date of Marriage: _____

and I hereby designate as my:

SECOND BENEFICIARY(IES):

Name: _____

Address: _____

Soc. Sec. #/Telephone No.: _____
Date of Birth/Relationship: _____
If Spouse-Date of Marriage: _____

Name: _____

Address: _____

Soc. Sec. #/Telephone No.: _____
Date of Birth/Relationship: _____
If Spouse-Date of Marriage: _____

Of any and all benefits from the IATSE National Health and Welfare Fund, as a result of my death.

_____ (Signature)

_____ (Date)

PLEASE HAVE THIS FORM WITNESSED:

_____ Witness

_____ (Date)

417 Fifth Avenue • 3rd Floor • New York, NY 10016-2204 · Main: 212.580.9092 · Toll-free: 800.456.FUND (3863)