Local 705 International Brotherhood of Teamsters Health & Welfare Plan
1645 West Jackson Boulevard, Suite 700, Chicago, Illinois 60612

BENEFICIARY DESIGNATION FORM

For purposes of the Death Benefit under the Health & Welfare Plan.

Name of Participant: _____ SSN: XXX-XX- _____
Address: _____

Please name your Primary Beneficiary(ies) below.
(If you name multiple beneficiaries, the payment will be paid in equal shares.)
You may attach an additional sheet, if necessary.

Name:		Relationship:
Date of Birth:	SSN:	Phone No:
Address:		Email:

Name:		Relationship:
Date of Birth:	SSN:	Phone No:
Address:		Email:

Name:		Relationship:
Date of Birth:	SSN:	Phone No:
Address:		Email:

Name:		Relationship:
Date of Birth:	SSN:	Phone No:
Address:		Email:

Please name your Secondary Beneficiary(ies), if any, below.
(In the event all primary beneficiaries predecease me, the death benefit will be paid in equal shares to the following secondary beneficiaries.) You may attach an additional sheet, if necessary.

Name:		Relationship:
Date of Birth:	SSN:	Phone No:
Address:		Email:

Name:		Relationship:
Date of Birth:	SSN:	Phone No:
Address:		Email:

Name:		Relationship:
Date of Birth:	SSN:	Phone No:
Address:		Email:

Name:		Relationship:
Date of Birth:	SSN:	Phone No:
Address:		Email:

I understand that this designation form supersedes any designations previously submitted.

SIGNATURE: _____ **DATE:** _____