CENTRAL ILLINOIS CARPENTERS HEALTH & WELFARE TRUST FUND

Life Insurance Beneficiary Designation Form

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Instructions: Print clearly in ink. You must complete the form in full, sign and return it to the Fund Office.
If the percent field is left blank, the designated beneficiaries will share equally. Percentages (100%, 75%, 25%, etc.) should be entered. If any designated beneficiary dies before the Participant, the share that such beneficiary would have received if he/she had survived the Participant's death will be payable equally to the remaining designated beneficiaries who survive the Participant. The following information is required for each beneficiary. There is additional space on the back of the form for adding contingent beneficiaries.

- Beneficiary's full name (e.g., Mary B. Jones, not Mrs. John J. Jones);
- Relationship to Participant (if not related to Participant, show as "friend"); and
- Address, Birth date, and Social Security Number. Note if a SS # or ITIN is not provided, it may be difficult to locate a beneficiary should their address change.

A Participant should review his/her beneficiary designation when the Participant's marital status changes, has a child, or the Participant experiences another major life event.

Participant's Last Name(s)	First Name in Full	Middle Name or Initial

Home Address	City, State and Zip

Date Of Birth			Sex	Marital Status	Social Security #
MONTH	DAY	YEAR	☐ Male ☐ Female	☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	- -

Primary Beneficiaries - In the event of my death, my life insurance benefit should be paid to:

Primary Beneficiary's First Name	M.I.	Last Name	Percent
Relationship to Participant	Birth Date of Beneficiary	SS# or ITIN of Beneficiary	
Street Address of Beneficiary	City	State	Zip
Cell Phone Number of Beneficiary, including Area Code	Email Address of Beneficiary		

Primary Beneficiary's First Name	M.I.	Last Name	Percent
Relationship to Participant	Birth Date of Beneficiary	SS# or ITIN of Beneficiary	
Street Address of Beneficiary	City	State	Zip
Cell Phone Number of Beneficiary, including Area Code	Email Address of Beneficiary		

Primary Beneficiary's First Name	M.I.	Last Name	Percent
Relationship to Participant	Birth Date of Beneficiary	SS# or ITIN of Beneficiary	
Street Address of Beneficiary	City	State	Zip
Cell Phone Number of Beneficiary, including Area Code	Email Address of Beneficiary		

Primary Beneficiary's First Name	M.I.	Last Name	Percent
Relationship to Participant	Birth Date of Beneficiary	SS# or ITIN of Beneficiary	
Street Address of Beneficiary	City	State	Zip
Cell Phone Number of Beneficiary, including Area Code	Email Address of Beneficiary		

Contingent Beneficiaries – If the primary beneficiary(ies) above are deceased, pay the life insurance benefit to:

Contingent Beneficiary's First Name	M.I.	Last Name	Percent

Relationship to Participant	Birth Date of Beneficiary	SS# or ITIN of Beneficiary

Street Address of Beneficiary	City	State	Zip

Cell Phone Number of Beneficiary, including Area Code	Email Address of Beneficiary

Contingent Beneficiary's First Name	M.I.	Last Name	Percent

Relationship to Participant	Birth Date of Beneficiary	SS# or ITIN of Beneficiary

Street Address of Beneficiary	City	State	Zip

Cell Phone Number of Beneficiary, including Area Code	Email Address of Beneficiary

Contingent Beneficiary's First Name	M.I.	Last Name	Percent

Relationship to Participant	Birth Date of Beneficiary	SS# or ITIN of Beneficiary

Street Address of Beneficiary	City	State	Zip

Cell Phone Number of Beneficiary, including Area Code	Email Address of Beneficiary

Contingent Beneficiary's First Name	M.I.	Last Name	Percent

Relationship to Participant	Birth Date of Beneficiary	SS# or ITIN of Beneficiary

Street Address of Beneficiary	City	State	Zip

Cell Phone Number of Beneficiary, including Area Code	Email Address of Beneficiary

I hereby revoke all previous life insurance beneficiary designations and hereby designate the above as my beneficiary(ies). I understand that I may change my beneficiary designation(s) at any time by completing a Life Insurance Beneficiary Designation Form. Such a change shall become effective when the completed form is received by the Central Illinois Carpenters Health and Welfare Trust Fund office.

I understand that receipt of this form is not a guarantee of eligibility for benefits.

Sign & Date Here	Participant's Signature in Full	Date Signed

Signature and date are required. Invalid without participant signature and date of signature.

For Office Use Only
Membership Services Representative (Date & Initials)