SANTA MONICA UNITE HERE
HEALTH BENEFIT TRUST FUND

Administered By: Benefit Programs Administration
Telephone • (866) 345-5189 • (562) 463-5075 • FAX (562) 463-5894
www.santamonicauniteherefunds.org

LIFE INSURANCE BENEFICIARY DESIGNATION FORM

Name of Participant _____ Social Security Number _____

Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Telephone _____ Gender M F (circle one)

Marital Status (circle one): Single Married Divorced

Employer _____ Date of Hire _____

LIFE INSURANCE BENEFICIARY DESIGNATION: I hereby designate the following person(s) as my beneficiary for my life insurance benefits payable under the Santa Monica UNITE HERE Health Benefit Fund. Please print when providing the beneficiary information below.

Beneficiary Name(s): _____ **Relationship:** _____
Social Security Number: _____ (Spouse, Child, Etc.)
Address: _____

Beneficiary Name(s): _____ **Relationship:** _____
Social Security Number: _____ (Spouse, Child, Etc.)
Address: _____

Beneficiary Name(s): _____ **Relationship:** _____
Social Security Number: _____ (Spouse, Child, Etc.)
Address: _____

Beneficiary Name(s): _____ **Relationship:** _____
Social Security Number: _____ (Spouse, Child, Etc.)
Address: _____

Participant Signature: _____ **Date:**_____

RETURN COMPLETED BENEFICIARY DESIGNATION FORM TO:
Santa Monica UNITE HERE Health Benefit Fund
1200 Wilshire Blvd, Fifth Floor, Los Angeles, CA 90017-1906