MICHIANA AREA ELECTRICAL WORKERS' HEALTH AND WELFARE FUND BENEFICIARY DESIGNATION FORM

Participant Name (Please Print):_____

Address:_____

_____

Social Security Number:_____ Date of Birth:_____

☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

HEALTH CARE FUND DEATH BENEFIT BENEFICIARY INFORMATION:

Primary Beneficiary (You may name one or more)*

Name (Please Print):_____

Address:_____

_____

Social Security Number:_____ Date of Birth:_____

Relationship:_____ Share:_____

Secondary Beneficiary (You may name one or more)*

Name (Please Print):_____

Address:_____

_____

Social Security Number:_____ Date of Birth:_____

Relationship:_____ Share:_____%

_____ _____

Date Participant's Signature

PLEASE RETURN THIS FORM TO: MICHIANA AREA ELECTRICAL WORKERS' HEALTH AND WELFARE FUND
6525 Centurion Drive
Lansing, MI 48917-9275

**If you have any questions, please contact the Fund Office toll free 1-877-244-9473. Office hours are Monday through Friday 7:30 a.m.–5:30 p.m. Eastern Standard Time (EST).

**If you want more than one person to share your benefit, please indicate the percent you wish each to receive.*