Health and Welfare Fund Office for UFCW and Employers
Fax To: 901-758-3021
Upload: www.bams.bz
Mail To: 661 N. Ericson Road Cordova TN, 38018

## Beneficiary Form for Death Benefit

**See the Plan's SPD for all terms related to the Death Benefit and Accidental Death and Dismemberment Benefit. This form will be used to pay the employee's life benefits to the beneficiary assigned on the form.**

**Employee Name**: (First)_____(Middle Initial) _____(Last Name) _____
Social Security No._____-_____-_____Telephone # (___) _____--_____Email: _____

Address: (No. and Street)_____, (City)_____, (State and Zip Code) _____

Date of Birth:_____/_____/_____Gender: _____

I, the undersigned, hereby revoke all prior beneficiary designations made by me and hereby direct that any benefits payable under the Fund upon my death be payable to the following primary beneficiary(ies). In the event my primary beneficiary (or all my primary beneficiaries) dies or disclaim the benefit the full number of benefits, if any, has been paid, I direct that my entire remaining interest in the Fund be paid to the following contingent beneficiary(ies). This beneficiary designation is effective when received by the Fund Office. If additional beneficiaries are needed, please attach a separate page listing the names and percentage amount.

YOUR BENEFICIARY IS THE PERSON OR PERSONS YOU WISH TO RECEIVE YOUR LIFE INSURANCE PROCEEDS.
PLEASE DO NOT NAME YOURSELF

| Name | Address | Date of Birth | Telephone # | Relationship |
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Unless otherwise provided where two or more beneficiaries are named the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy. This designation revokes all previous designations. The right to further change the beneficiary is reserved unto the insured.

**Signature of Employee**_____ **Date**_____