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.

Beneficiary Name(s):_____________________________ **Relationship:**_________________
(Please Print) (Spouse, Child, Ect..)

Beneficiary Name(s):_____________________________ **Relationship:**_________________
(Please Print) (Spouse, Child, Ect..)

Beneficiary Name(s):_____________________________ **Relationship:**_________________
(Please Print) (Spouse, Child, Ect..)

Beneficiary Name(s):_____________________________ **Relationship:**_________________
(Please Print) (Spouse, Child, Ect..)

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