MICHIGAN LABORERS' HEALTH CARE FUND
BENEFICIARY DESINGATION FORM

(To be completed by participant)

PLEASE PRINT

Purpose for Completing Form:
□ New Participant □ Change Beneficiary □ Address Change □ Name Change_____
(previous name)

NAME OF PARTICIPANT:

Last First MI

SOCIAL SECURITY NUMBER:	**PARTICIPANT DATE OF BIRTH:** Month Day Year
ADDRESS OF PARTICIPANT: Street City State ZIP	
GENDER ☐ M ☐ F	**MARITAL STATUS** ☐ Single ☐ Married ☐ Divorced ☐ Widowed
PARTICIPANT PHONE NUMBER: ( )	**PARTICIPANT EMAIL ADDRESS:**

LOCAL UNION NO:

Health Care Fund Death Benefit – You may designate anyone. If you do not designate a beneficiary, any benefits payable upon your death will be paid in the order of preference outlined in the Health Care Fund Plan Booklet.

NAME OF BENEFICIARY:

Last First MI

RELATIONSHIP:

ADDRESS OF BENEFICIARY:

Street City State ZIP

SOCIAL SECURITY NUMBER:	**DATE OF BIRTH:** Month Day Year

I understand that this beneficiary designation supersedes any previous designation signed prior to the date shown below.

DATE OF SIGNATURE	**SIGNATURE**

For questions, contact the Administration Office at 877-MI-LABOR (877-645-2267)
Return completed form to:

Michigan Laborers' Health Care Fund
Administration Office, P.O. Box 211133, Eagan MN 55121-2533
or Fax to: (517) 689-6016

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