

I.A.T.S.E. HEALTH AND WELFARE FUND BENEFICIARY DESIGNATION

Participant Name:	
Address:	
rantcipant's social security #.	Date of Birth
designate as my:	es and Regulations of the IATSE National Health and Welfare Fund, I hereby
	Primary Beneficiary(ies):
Name	
Address	
Social Security #	
Relationship	
Telephone #	e-mail address
Name	
Address	
Social Security #	
Relationship	
Telephone #	e-mail address
S	econdary Beneficiary(ies):
Name	
Address	
Social Security #	
Relationship	
Telephone #	e-mail address
Name	
Address	
Social Security #	Date of Birth
Relationship	
Telephone #	e-mail address
Of any and all benefits from the IATSE Nati	ional Health and Welfare Fund, as a result of my death.
(Participant Signature)	(date)
Please have this form witnessed:	
Witness	(date)