PLUMBERS AND PIPEFITTERS LOCAL UNION NO. 333
HEATLH AND WELFARE FUND

6525 Centurion Drive • Lansing, Michigan 48917
Phone (517) 321-7502 Toll Free (866) 348-9499 FAX (517) 321-7508

LIFE INSURANCE BENEFICIARY DESIGNATION FORM

You may use this form to designate who will receive the Group Life Insurance Benefits from the Plumbers and Pipefitters Local 333 Health and Welfare Funds in the event of your death.

The designations you make on this form replace any prior beneficiary designations.

Name_____
(Last) (First) (Middle Initial)

Street Address_____

City_____ **State**_____ **Zip Code** _____

Social Security Number_____ **Date of Birth**_____ **Gender** ☐ **Male** ☐ **Female**
(Month) (Day) (Year)

MARTIAL STATUS: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

BENEFICIARY DESIGNATION:

For primary beneficiaries, indicate who should receive the group life insurance proceeds in the event of your death.

For secondary, (also known as contingent) beneficiaries, indicate who should receive the group life insurance proceeds in the even that ALL of your primary beneficiaries are not living at the time of your death.
Please make your beneficiary designation(s) below. If you need more space, attach another sheet to this form.

You may designate more than one Primary or Secondary Beneficiary. If you do, make sure to indicate the percentage share each should have. The total within each class (Primary and Secondary**) must equal 100%**. If you do not specify percentages, surviving beneficiaries within the class will share proceeds equally.

	Primary beneficiary(ies)	**Social Security number**	**Relationship to employee**	**Percent share of proceeds***
1.	**Name:**_____	_____	_____	_____**%**
	Address:_____			
2.	**Name:**_____	_____	_____	_____**%**
	Address:_____			

	Secondary (Contingent) beneficiary(ies)	**Social Security number**	**Relationship to employee**	**Percent share of proceeds***
1.	**Name:**_____	_____	_____	_____**%**
	Address:_____			
2.	**Name:**_____	_____	_____	_____**%**
	Address:_____			

Benefits will be paid in accordance with the Eligibility and Plan Provisions. Please refer to your Summary Plan Description for more information.

Signature: _____ Date: _____