UFCW LOCAL 360 HEALTH FUND

48 STILES LANE, SUITE 204, PINE BROOK, NJ 07058
TEL: (973) 299-6700 FAX: (973) 299-1288

BENEFICIARY DESIGNATION FORM

MEMBER NAME: ______________________ ID: ______________________ Company Name ______________________
DOB: ______________ SSN: ______________________
Address: ______________________ City: ______________ State: ________ Zip: ______________
Phone: ______________ Mobile: ______________ Email: ______________________

It is important that your beneficiary designation be clear so that there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary(ies). When naming your beneficiary(ies) please indicate their full name, address, social security number, birth date and relationship. If the beneficiary is not related either by blood or marriage, insert the words, "Not Related". Primary beneficiaries are first to receive. Contingent beneficiaries will only receive benefits if all primary beneficiaries are deceased. All Primaries listed should equal 100%. All Contingents listed should equal 100%.

Beneficiary Designation: BE SURE TO READ INSTRUCTIONS ABOVE

NAME ______________________ DOB: ________ SSN: ______________ Relation ______________
Address: ______________________ City: ______________ State: ________ Zip: ______________
Phone: ______________ Mobile: ______________ Email: ______________________
[ ] Primary or [ ] Contingent Percentage of Benefit [ ] 100% [ ] 66.6% [ ] 50% [ ] 33.3% [ ] 25%

NAME ______________________ DOB: ________ SSN: ______________ Relation ______________
Address: ______________________ City: ______________ State: ________ Zip: ______________
Phone: ______________ Mobile: ______________ Email: ______________________
[ ] Primary or [ ] Contingent Percentage of Benefit [ ] 100% [ ] 66.6% [ ] 50% [ ] 33.3% [ ] 25%

NAME ______________________ DOB: ________ SSN: ______________ Relation ______________
Address: ______________________ City: ______________ State: ________ Zip: ______________
Phone: ______________ Mobile: ______________ Email: ______________________
[ ] Primary or [ ] Contingent Percentage of Benefit [ ] 100% [ ] 66.6% [ ] 50% [ ] 33.3% [ ] 25%

NAME ______________________ DOB: ________ SSN: ______________ Relation ______________
Address: ______________________ City: ______________ State: ________ Zip: ______________
Phone: ______________ Mobile: ______________ Email: ______________________
[ ] Primary or [ ] Contingent Percentage of Benefit [ ] 100% [ ] 66.6% [ ] 50% [ ] 33.3% [ ] 25%

I hereby revoke any previous beneficiary designation(s), if any, for my death benefit and/or accidental death and dismemberment (AD&D) benefit issued to me under the Local 360 Health Fund, and direct that the benefits payable under the Plan be paid as indicated above. I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Member Signature: ______________________ Date Signed: ______________________