



**Laborers Health and Welfare Trust Fund for Northern California**  
220 Campus Lane, Fairfield, CA 94534-1498 • Telephone: (707) 864-2800 • Toll Free: 1-(800) 244-4530

## Beneficiary Designation

**I hereby designate as my Beneficiary(ies) to receive the Health & Welfare Death Benefits, if any, payable at my death under the Rules and Regulations of the Plan.**

(1) NAME OF BENEFICIARY

RELATIONSHIP

ADDRESS: STREET

CITY

STATE

ZIP CODE

(2) NAME OF BENEFICIARY

RELATIONSHIP

ADDRESS: STREET

CITY

STATE

ZIP CODE

(3) NAME OF BENEFICIARY

RELATIONSHIP

ADDRESS: STREET

CITY

STATE

ZIP CODE

(4) NAME OF BENEFICIARY

RELATIONSHIP

ADDRESS: STREET

CITY

STATE

ZIP CODE

My signature below acknowledges my understanding of the following:

1. No beneficiary has the right to name an additional beneficiary or have the benefits transfer to his or her estate.
2. If more than one person is named as beneficiary and becomes entitled to benefits at my death, payment will be made in equal shares to the surviving beneficiary(ies).
3. If any beneficiary(ies) predeceases me, payment will be made in equal shares to the surviving beneficiary(ies).
4. The designated beneficiary(ies) appearing above supersedes any previous designation of a beneficiary(ies).

EMPLOYEE'S SIGNATURE

DATE

EMPLOYEE'S SOC. SEC. NO.

WITNESS' SIGNATURE

DATE

PRINT NAME  
OF WITNESS

ADDRESS: STREET

CITY

STATE

ZIP CODE