Member's SSN or Member Id:

____

Change of Beneficiary Form

WISCONSIN LABORERS' HEALTH FUND

4633 LIUNA WAY, SUITE 201 DE FOREST, WI 53532-2510
TELEPHONE: 608-842- 9102 TOLL FREE: 800-397-3373
WEBSITE: WWW.WILBENEFITS.COM

LiUNA! WISCONSIN LABORERS' HEALTH FUND *Feel the Power*

ONLY FOR PARTICIPANTS WITH DEATH BENEFIT COVERAGE AT THE TIME OF DEATH

Complete, sign (including witness signature), and return to Wisconsin Laborers' Health Fund (WLHF) if you wish to change your beneficiary (ies) currently indicated on your enrollment form. If you do not indicate the percentage of benefit, for multiple beneficiaries, they will receive equal shares of your death benefit. If "100% of Benefits" is listed for more than one beneficiary, the first beneficiary listed will receive 100% of the benefit and each succeeding beneficiary will be entitled to payment only if the prior beneficiary dies before the participant. Before payment of a death benefit can be made to a minor beneficiary, an affidavit of guardian of said minor must be provided to the fund to ensure guardian has full authority to access, receive, and disperse of the named minor's assets.

Name of Beneficiary (Last-First-Middle) ____________________	Full Address of Beneficiary (City, State, Zip Code) ____________________	Phone Number (___) ___-____	% of Benefit ____%	Relationship ________	Social Security Number ___-__-____
Name of Beneficiary (Last-First-Middle) ____________________	Full Address of Beneficiary (City, State, Zip Code) ____________________	Phone Number (___) ___-____	% of Benefit ____%	Relationship ________	Social Security Number ___-__-____
Name of Beneficiary (Last-First-Middle) ____________________	Full Address of Beneficiary (City, State, Zip Code) ____________________	Phone Number (___) ___-____	% of Benefit ____%	Relationship ________	Social Security Number ___-__-____
Name of Beneficiary (Last-First-Middle) ____________________	Full Address of Beneficiary (City, State, Zip Code) ____________________	Phone Number (___) ___-____	% of Benefit ____%	Relationship ________	Social Security Number ___-__-____
Name of Beneficiary (Last-First-Middle) ____________________	Full Address of Beneficiary (City, State, Zip Code) ____________________	Phone Number (___) ___-____	% of Benefit ____%	Relationship ________	Social Security Number ___-__-____

Back of Form Must Be Completed

By signing this form, I certify that the information provided is complete and accurate as of the date of my signature.

_____	_____	_____
Member Name (Please Print)	Member Signature	Date

One of the options below must be completed, at time of member signature, in order for the form to be accepted

Option One – Notarized

The Foregoing document was signed before me this _____ day of _____ 20____

_____
Notary Public

My Commission Expires: _____

Place Notary Stamp Below

Option Two – Non-Relative Witness

_____ _____
Witness Signature Date

_____
Relationship to Member **- Must Be a Non-Relative**

Please Return Your Form One of the Following Ways:

Mail:
Wisconsin Laborers' Health Fund
Attn: Eligibility
4633 Liuna Way
Deforest, WI 53532

Upload to Website:
Scan document and save to computer as PDF
Visit www.wilbenefits.com
Scroll to "upload document to eligibility department"
Browse for saved PDF
Upload

Fax:
(608) 846-3192
Wisconsin Laborers' Health Fund
Attn: Eligibility

Email:
EligibilityWL@benesys.com
Please Put "Change of Beneficiary Form" as Subject