Teamsters Joint Council No. 83 of Virginia Health & Welfare and Pension Funds

www.tjc83funds.org
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Health & Welfare Beneficiary Designation/Change Form

In accordance with the terms of the Group Coverage and Plan of Benefits as provided by Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund, request is hereby made for a change of beneficiary.

Participant's Name_____ ID# _____

Participant's Phone Number _____

Please provide the following information on your new beneficiary:

Name _____
First *Middle Initial* *Last*

Address _____
Street *City* *State* *Zip*

Relationship to Participant _____ Date of Birth _____

Beneficiary's SS # _____

Use space below for complex designations of beneficiary.

_____
_____
_____
_____
_____

Insured's Signature _____ Date_____

Witness' Signature _____ Date_____

****This information is not valid without witness' signature. Witness cannot be the beneficiary.****

If no beneficiary survives the insured, payment shall be made in accordance with the terms of the plan. If more than one beneficiary is named, payment shall be made in equal shares to the beneficiaries who survive the insured, unless otherwise provided. The right to further change the beneficiary is reserved unto the insured without the consent of the beneficiary. If the insured is also insured under a Group Accidental Death and Dismemberment Plan issued by the Teamsters Joint Council No. 83 of Virginia Health and Welfare Fund, this beneficiary designation shall also apply to this benefit.