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

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HEALTH & WELFARE CHANGE OF BENEFICIARY FORM

Please complete the form below and return it to the Fund Office using the contact information listed above.

This section must be completed by Participant.	
Participant's Name	Participant's SSN or UID
Participant's Mailing Address	City, State Zip
Participant's Email Address	Participant's Phone No.
This section applies to your new beneficiary.	
Beneficiary's Name	Beneficiary's SSN
Beneficiary's Address	City, State Zip
Relationship to Participant	Beneficiary's Date of Birth
For complex beneficiary designations, use space below. If you are designating more than one beneficiary, please also designate percentages.	
Participant's Signature	Date
Witness' Signature	Date

This beneficiary designation is not valid without a 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.