

# IATSE National Benefit Funds



FROM: Benefit Fund Participant Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
TO: IATSE National Health and Welfare Fund – Board of Trustees Soc. Sec. #: \_\_\_\_\_  
RE: Designation of Beneficiary Date of Birth: \_\_\_\_\_

In accordance with the provisions of the Rules and Regulations of the IATSE National Health and Welfare Fund, I hereby designate as my:

**PRIMARY BENEFICIARY (IES):**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Soc. Sec. #/Telephone No.: \_\_\_\_\_  
Date of Birth/Relationship: \_\_\_\_\_  
If Spouse-Date of Marriage: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Soc. Sec. #/Telephone No.: \_\_\_\_\_  
Date of Birth/Relationship: \_\_\_\_\_  
If Spouse-Date of Marriage: \_\_\_\_\_

and I hereby designate as my:

**SECOND BENEFICIARY (IES):**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Soc. Sec. #/Telephone No.: \_\_\_\_\_  
Date of Birth/Relationship: \_\_\_\_\_  
If Spouse-Date of Marriage: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Soc. Sec. #/Telephone No.: \_\_\_\_\_  
Date of Birth/Relationship: \_\_\_\_\_  
If Spouse-Date of Marriage: \_\_\_\_\_

Of any and all benefits from the IATSE National Health and Welfare Fund, as a result of my death.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**PLEASE HAVE THIS FORM WITNESSED:**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
(Date)