

### Designation of Beneficiary for Death Benefit

Member Last Name	First Name	Middle Initial	Member UFCW Health Card ID# or SS#	Member Daytime Phone#
Member Street Address		City	State	Zip Code

**Primary Beneficiary(ies)**

First Name	Last Name	Relationship	Date of Birth	SS#		% of benefit

**Contingent Beneficiary(ies)**

First Name	Last Name	Relationship	Date of Birth	SS#	Full Address	% of benefit

I hereby direct that, in the event of my death, any death benefits due under the Plan be paid to the Primary Beneficiary(ies) named above, or if no Primary Beneficiary survives me, to the Secondary Beneficiary(ies) named above. I also revoke any and all prior beneficiary designations made by me relative to the Plan and reserve the right to revoke or change this designation at any time. This designation shall become effective upon its receipt by the Fund Office until replaced by a later designation.

\_\_\_\_\_  
Member's Signature

\_\_\_\_\_  
Member's Social Security No.

\_\_\_\_\_  
Member's Name (please print)

\_\_\_\_\_  
Date

**Return completed form to:**

**UFCW Benefits Fund Office  
c/o Wilson-McShane Corporation  
1431 Opus Place, Suite 350  
Downers Grove, IL 60515**