MICHIGAN CARPENTERS' HEALTH CARE FUND
BENEFICIARY DESIGNATION FORM

(To be completed by the participant)

Participant Name:_____

Address:_____

_____

Social Security Number or Participant Identification Number_____

Date of Birth:_____ ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Participants Telephone Number:_____Local Union Number:_____

HEALTH CARE FUND DEATH BENEFIT BENEFICIARY

Name:_____

Address:_____

_____

Social Security Number:_____ Date of Birth:_____

Relationship:_____

I understand that this beneficiary designation cancels any previous designation I may have made

_____ _____

Date Participant Signature

Except for your signature, please PRINT or type all other information.

Return completed form to:

Michigan Carpenters' Health Care Fund
6525 Centurion Drive
Lansing, MI 48917

For questions, contact the Fund Office toll free at 1-877-273-5739
Office hours: Monday through Friday 7:30 a.m.–5:30 p.m. (EST)