ADMINISTERED BY UNITED ADMINISTRATIVE SERVICES	**BAY AREA ROOFERS HEALTH & WELFARE PLAN GROUP** **LIFE BENEFICIARY ENROLLMENT APPLICATION** P.O. BOX 5057 SAN JOSE, CA 95150	TRUST FUND USE ONLY ☐ NEW EMPLOYEE ☐ CHANGE ☐ OPEN ENROLL. ☐ COBRA ☐ DELETION
PLEASE PRINT IN INK OR TYPE	LIFE CLAIMS CANNOT BE PROCESSED UNLESS YOUR ENROLLMENT CARD IS ON FILE	INSURANCE EFF. DATE _____ DATE _____INITIAL _____

PARTICIPANT INFORMATION

_____ ___/___/___ ___/___/___

LAST FIRST M.I. SOCIAL SECURITY NUMBER DATE OF BIRTH

_____ _____ _____ _____

ADDRESS CITY STATE ZIP CODE

LOCAL NO. _____ ☐ MALE ☐ FEMALE RETIRED ☐ YES ☐ NO EMPLOYER _____

BENEFICIARY INFORMATION

I UNDERSTAND THAT THE BENEFICIARY INDICATED BELOW WILL RECEIVE UPON MY DEATH ALL PROCEEDS FROM THE FOLLOWING:

1) LIFE INSURANCE BENEFIT WITH THE BAY AREA ROOFERS HEALTH AND WELFARE TRUST FUND
2) AMOUNTS PAYABLE TO ME FROM THE FOLLOWING APPLICABLE VACATION FUND: EAST BAY/ NORTH BAY ROOFERS VACATION PLAN, ROOFERS LOCAL UNION NO. 40 AREA VACATION PLAN OR THE SANTA CLARA COUNTY ROOFERS VACATION PLAN

_____ ___/___/___ _____

NAME (LAST) OF BENEFICIARY FIRST M.I. DATE OF BIRTH RELATIONSHIP

_____ _____ _____ _____

ADDRESS OF BENEFICIARY CITY STATE ZIP CODE

IF THE BENEFICIARY DIES BEFORE ME, I DESIGNATE AS CONTINGENT BENEFICIARY:

_____ ___/___/___ _____

NAME (LAST) OF CONTINGENT BENEFICIARY FIRST M.I. DATE OF BIRTH RELATIONSHIP

_____ _____ _____ _____

ADDRESS OF CONTINGENT BENEFICIARY CITY STATE ZIP CODE

IF THE BENEFICIARY IS A MINOR, PLEASE PROVIDE NAME OF GUARDIAN: _____

_____ _____ _____ _____

ADDRESS OF GUARDIAN CITY STATE ZIP CODE

SHOULD I WISH TO DESIGNATE A SEPARATE BENEFICIARY FOR THE AMOUNTS PAYABLE TO ME FROM THE APPLICABLE VACATION PLAN LISTED IN (2) ABOVE, I HEREBY DESIGNATE THE FOLLOWING BENEFICIARY (THE BENEFICIARY LISTED ABOVE WILL CONTINUE TO RECEIVE THE PROCEEDS FROM THE LIFE INSURANCE BENEFIT DESCRIBED IN (1)):

_____ ___/___/___ _____

NAME (LAST) OF BENEFICIARY FIRST M.I. DATE OF BIRTH RELATIONSHIP

_____ _____ _____ _____

ADDRESS OF BENEFICIARY CITY STATE ZIP CODE

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY THE TRUST FUND ADMINISTRATOR OF ANY CHANGE OF ADDRESS FOR MYSELF OR MY DEPENDENTS. I HEREBY CERTIFY UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION GIVEN IN THIS FORM IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I RESERVE THE RIGHT TO REVOKE OR CHANGE ANY BENEFICIARY DESIGNATION BY SUBMITTING A NEW FORM. THIS FORM SUPERSEDES ANY PRIOR BENEFICIARY DESIGNATION.

_____ _____

SIGNATURE DATE SIGNED