BENEFICIARY FORM
Retiree/Disability Life Insurance

MEMBERS NAME: ____

MEMBERS SOC.SEC.# __________/__________/__________

The UFCW District Union Local One Health Care Plan is hereby notified that my beneficiary(s) shall be:

Beneficiary(s): please put address and phone number if available.

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Signature of Member ***Date***

NOTE: The beneficiary form must be witnessed by someone other than the beneficiary(s) or a relative:

____ ____________________

Signature of Witness ***Date***