

**Please Print:**

MEMBER NAME \_\_\_\_\_

S.S. \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SEX M/F \_\_\_\_\_ TEL (\_\_\_\_) \_\_\_\_\_ DOB \_\_\_\_\_

LOCAL UNION \_\_\_\_\_ INITIATION DATE \_\_\_\_\_

BENEFICIARY \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

"I revoke all previous beneficiary designations and make the following nomination in respect to all death benefits provided now or in the future under the Massachusetts Laborers' Health & Welfare Plan. I reserve to myself the right of further and future changes."

X \_\_\_\_\_  
SIGNATURE OF MEMBER

\_\_\_\_\_  
WITNESS OTHER THAN BENEFICIARY OR MINOR DATE

**PLEASE PRINT LEGIBLY OR TYPE**

IN THE SPACE PROVIDED BELOW, PLEASE LIST THE NAMES AND DATE OF BIRTH OF ALL YOUR DEPENDENTS INDICATING SEX (M OR F) AND RELATIONSHIP.

(S = SPOUSE — C = CHILD)



M = MALE  
F = FEMALE

S = SPOUSE  
C = CHILD

DEPENDENT NAME	SEX	DOB	REL

**COMPLETE ALL QUESTIONS**