MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND
P.O. Box 1501 • 1400 District Avenue, Suite 200 • Burlington, MA 01803

Designation of Beneficiary of Health and Welfare Benefits:

Member's Name ______________________ SS# ______________ Local Union # __________

Address ____
Street City State Zip Code

Tel. ____________________ Date of Birth ______________

Beneficiary Name ______________________ SS# ______________ Tel. __________

Beneficiary Name ______________________ SS# ______________ Tel. __________

Address ____
Street City State Zip Code

Relationship to Member ______________________ Date of Birth ______________

"I revoke all previous beneficiary designations and make the following nominations in the respect to all death benefits provided now, or in the future under the Massachusetts Laborers' Health and Welfare Fund **ONLY,** and that any beneficiary designation to the Pension and/or Annuity Funds will require separate and independent forms from each Fund. I reserve to myself the right of further and future changes."

______________________ __________ ______________________ __________
Signature of Member Date Signature of Witness (Other Than Beneficiary) Date