UFCW Unions and Employers Health and Welfare Plan of Central Ohio

First Floor,
4150 E. MAIN STREET COLUMBUS, OHIO 43213-2962

FAX (614) 338-0226
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Please complete the following information to designate a change in your beneficiary(ies) for your group life insurance benefits. The designation listed on this form will replace any prior beneficiary designation. Please be sure to sign and date the form at the bottom.

Beneficiary Designation for Death Benefits – Designations are effective upon receipt by Plan Office

Primary Beneficiary(ies): I, the undersigned, hereby revoke any and all prior beneficiary designations made by me with respect to the UFCW Unions' and Employers' Health and Welfare Plan of Central Ohio (the "Health and Welfare Plan") and herebydirectthat any benefits payable under the Health and Welfare Plan upon my death be paid to the following primary beneficiary (or equally to the following primary beneficiaries). This beneficiary designation is effective when received by the Plan office.

Name	Social Security #	Relationship	Address, City, State & Zip	%

Contingent Beneficiary(ies): In the event all of the above named beneficiaries die or disclaim benefits before the full amount of benefits, if any, has been paid, I direct that my entire remaining interest in the Health and Welfare Plan be paid to the following contingent beneficiary (or equally to the following contingent beneficiaries). This contingent beneficiary designation is effective when received by the Plan office.

Name	Social Security #	Relationship	Address, City, State & Zip	%

Employee Name: _____ Policy ID Number: _____
(Please print) (or social security number)

Employee Signature: _____ Date: _____

"DEDICATED TO THE SERVICE OF THE MEMBERS IN TIME OF NEED"