



CHANGE OF BENEFICIARY
LIFE INSURANCE ONLY
SIGN PICTORIAL & DISPLAY INDUSTRY
WELFARE FUND
 P.O. Box 2500
 San Francisco, CA 94126
 (415) 986-6276

THE PURPOSE OF THIS FORM IS TO CHANGE THE BENEFICIARY FOR YOUR LIFE INSURANCE BENEFITS UNDER THE HEALTH & WELFARE TRUST FUND. IT DOES NOT AFFECT THE BENEFICIARY FOR ANY OTHER BENEFITS.

PARTICIPANT DATA

LAST NAME		FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	
MAILING ADDRESS (STREET OR P.O. BOX)				SEX	DATE OF BIRTH
CITY	STATE/ZIP	TELEPHONE NUMBER ()		EMAIL ADDRESS	

I wish to change the beneficiary for my life insurance benefits to the following:

Primary Beneficiary	NAME		RELATIONSHIP
ADDRESS		TELEPHONE NUMBER	EMAIL ADDRESS
Secondary Beneficiary	NAME		RELATIONSHIP
ADDRESS		TELEPHONE NUMBER	EMAIL ADDRESS

By signing below, I acknowledge that this is a change in my beneficiary for life insurance benefits only.

Employee Signature

Date

INTERNAL OFFICE USE ONLY
