Office and Professional Employees Locals 30 & 537
Retirement and Health & Welfare Trust Funds

Telephone • (800) 386-4350 • (562) 463-5065 • Facsimile (562) 463-5894

LIFE INSURANCE BENEFICIARY FORM

(Please Type or Print Clearly)

Last Name | First | Middle | Social Security Number

Home Address | Date of Birth

City State and Zip | Local Union

Employer | Date Employed

Beneficiary for the policy shall be:

a)	Primary Beneficiary	Percentage	Relationship to Insured
b)	**Contingent Beneficiary (paid only if primary beneficiaries are deceased)**	**Percentage**	**Relationship to Insured**

Please include Beneficiary's address if is different from member's.

Signature - (This beneficiary designation cancels any prior beneficiary designation and shall be effective on the date received by the Administrative Office) | Date

DESIGNATING A BENEFICIARY

If one individual is designated, use their full name, for example "Mary J. Smith", not "Mrs. John Smith".

If two individuals are to be named, designate as follows: "Mary Smith, wife and Dorothy Smith, daughter."

Be sure to state the relationship, for example, "wife", "son", "daughter".

If more that one beneficiary is designated, benefits will be divided equally, unless you designated otherwise.

You must complete a new card to change your beneficiary designation. A card must be on file at the Administrative Office in order to be valid.

Contact the Administrative Office if you have any questions. (562) 463-5065 - (800) 386-4350

When form is completed mail to:

Office and Professional Employees Locals 30 & 537
Retirement and Health & Welfare Trust Funds
13191 Crossroads Parkway North, Suite 205
City of Industry CA 91746-3434