Print all entries except signature.
Please complete and return to:

CALIFORNIA SERVICE EMPLOYEES HEALTH AND WELFARE TRUST FUND
828 W. WASHINGTON BLVD., LOS ANGELES, CA 90015

Participant _____
LAST FIRST INITIAL

Social Security Number _____

Street Address _____

Date of Birth _____

City _____ State _____ Zip _____

Local Union No. _____

DESIGNATION OF BENEFICIARY

(Read explanation at bottom of card before completing)

I, _____ , Social Security No. _____ do hereby designate the following named person or persons as my beneficiaries to receive any monies that may be payable by reason of my death, under the California Service Employees Health and Welfare Trust Fund. Pay group death benefits, if applicable, to:

PRINT NAME OF BENEFICIARY RELATIONSHIP SOCIAL SECURITY NR.

STREET ADDRESS CITY STATE ZIP

EXPLANATION: *If you do not designate anybody, then applicable benefits will be payable as provided under the plan. If you are legally married and you designate someone other than your spouse, your spouse must sign below.*

I consent to my spouse's beneficiary designation(s) above.

SPOUSE'S SIGNATURE DATE MEMBER SIGNATURE DATE