I.A.T.S.E. HEALTH AND WELFARE FUND BENEFICIARY DESIGNATION

Participant Name: _____
Address: _____
_____
Participant's Social Security #: _____ Date of Birth _____

In accordance with the provisions of the Rules and Regulations of the IATSE National Health and Welfare Fund, I hereby designate as my:

Primary Beneficiary(ies):

Name _____
Address _____
_____
Social Security #_____ Date of Birth _____
Relationship _____
Telephone #_____ e-mail address_____

Name _____
Address _____
_____
Social Security #_____ Date of Birth _____
Relationship _____
Telephone #_____ e-mail address_____

Secondary Beneficiary(ies):

Name _____
Address _____
_____
Social Security #_____ Date of Birth _____
Relationship _____
Telephone #_____ e-mail address_____

Name _____
Address _____
_____
Social Security #_____ Date of Birth _____
Relationship _____
Telephone #_____ e-mail address_____

Of any and all benefits from the IATSE National Health and Welfare Fund, as a result of my death.

_____ _____
(Participant Signature) (date)

Please have this form witnessed:

_____ _____
Witness (date)

417 Fifth Avenue, 3rd Floor New York, N.Y. 10016-2204 Toll Free: 1-800-456-3863