Teamsters Union 25 Health Services & Insurance Plan

Schrafft's City Center • 529 Main Street, Suite 209 • Charlestown, MA 02129
Local phone: 617-241-9220 ext. 2 • In MA: 800-442-9939 • Outside MA: 800-225-6135
www.teamsterscare.com

Change of Beneficiary Form

TeamstersCare Life Insurance and Accidental Death & Dismemberment

Member Information (All Information Required)

SS# ☐☐☐ – ☐☐ – ☐☐☐☐
Social Security Number

First Name_____ MI_____ Last Name_____

Birth Date___/___/_____ Gender: ☒ Male ☒ Female Marital Status (Check One): ☒ Single ☒ Married ☒ Divorced ☒ Widowed

Address_____ City_____ State_____ Zip_____
Number & Street

Cell Phone:_____ Home Phone:_____

E-mail Address_____

Information About Your New Beneficiary or Beneficiaries

As long as you adhere to state or federal laws that apply, you can designate anyone you choose as your beneficiary - or you can name several people as multiple beneficiaries. Originally, you name your beneficiaries when you enroll in TeamstersCare, however you can change your designation at any time, provided you complete and submit this Change of Beneficiary form.

Designating Your Beneficiary or Beneficiaries

You may name one or more beneficiaries. If two or more primary beneficiaries are named and you do not list benefit percentages, proceeds will be paid in equal shares to the named beneficiaries who survive you. If you list benefit percentages, the total must equal 100%.

First Name_____ Last Name_____ Date of Birth___/___/_____ Relationship_____

Address_____ Benefit %_____
Number & Street City State Zip Phone number

First Name_____ Last Name_____ Date of Birth___/___/_____ Relationship_____

Address_____ Benefit %_____
Number & Street City State Zip Phone number

Contingent Beneficiary Designation - Person to receive benefits if your primary beneficiary(ies) is unable to. If more than one contingent is desired, please attach a separate sheet listing beneficiaries and benefit percentages.

First Name_____ Last Name_____ Date of Birth___/___/_____ Relationship_____

Address_____ Benefit %_____
Number & Street City State Zip Phone number

Acknowledgment and Signature

☐ ***I designate the above named person(s) as my beneficiary(ies). I understand that I can change them at any time by completing and submitting a new Change of Beneficiary Form to TeamstersCare.***

Member's Signature_____ Date_____