Benefit Fund for Hospital & Health Care Employees
Philadelphia and Vicinity
1319 Locust Street, Philadelphia, Pa 19107-5405
(215) 735-5720 • (800) 531-1199 • FAX (215) 985-9232
http://www.1199cfunds.org • info@1199cfunds.org

Beneficiary Information – Death Benefit

Please PRINT all information and SIGN where indicated

Your name _____

Your Social Security Number _____ _____ _____ Your date of birth _____

Your street address _____

City _____ State _____ Zip _____

Home phone _____ Work phone_____

Below, please name the person(s) to whom your Death Benefit is to be paid. Please provide ALL requested information. If your beneficiary is a minor, state her/his age and provide the name(s) of the person's parent(s) or guardian(s) in the "Remarks" section below. You may name more than one person to share the Death Benefit. Should you choose to do this, indicate the percentage each individual is to receive in the "Remarks" section below and indicate that ALL of your named beneficiaries are primary beneficiaries. Any person named as a secondary beneficiary will receive benefits only if the primary beneficiary dies before you.

Primary Beneficiary

Name of beneficiary _____

Social Security Number _____ _____ _____ Date of birth _____
No claims can be paid without the beneficiary's SSN and date of birth

Street address _____

City _____ State _____ Zip _____

Secondary Beneficiary

Name of beneficiary _____

Social Security Number _____ _____ _____ Date of birth _____
No claims can be paid without the beneficiary's SSN and date of birth

Street address _____

City _____ State _____ Zip _____

Remarks

_____

_____

_____

Your signature _____ **Today's date** _____