Health & Welfare Fund
LOCAL 399

DEPENDENT CHANGE FORM
CHANGE OF BENEFICIARY FORM

IUOE • Local 399 Health & Welfare Fund
2260 S. Grove Street • Chicago, IL 60616
Phone: (312) 372-9870 ***(Option 3)*** **• Fax: (312) 842-0291**

This form requires an original signature of the Member and should be hand delivered to the Health & Welfare Office or mailed to the Fund Office at the address listed above. You may request acknowledgement of receipt of this change form.

SECTION 1 – ADD A NEW SPOUSE (Attach Marriage Certificate)
This is to notify the Health & Welfare Fund that the following dependent **IS NOW ELIGIBLE** for the Plan:

NAME	BIRTHDATE	MARRIAGE DATE	SPOUSE SOCIAL SECURITY #

Does your new spouse have employer group coverage? ❒ YES ❒ NO If yes, please complete and attach a Coordination of Benefits form.

SECTION 2 – ADD A NEWBORN (Attach Birth Certificate or provide when received)
This is to notify the Health & Welfare Fund that the following dependent **IS NOW ELIGIBLE** for the Plan:

NAME	SON / DAUGHTER	BIRTHDATE

I authorize Local 399 to publish my newborn child's name in the "new additions" section of their newsletter publication ❒ YES ❒ NO

SECTION 3 – DELETE AN EXISTING DEPENDENT (Provide Divorce Decree and ex-spouse's address if applicable)
This is to notify the Health & Welfare Fund that the following dependent **IS NO LONGER ELIGIBLE** for the Plan:

NAME	RELATIONSHIP	REASON FOR TERMINATION	EFFECTIVE DATE

SECTION 4 – CHANGE OF BENEFICIARY
This is to notify the Health & Welfare Fund of **a change in beneficiary to the death benefit under Local 399's Health & Welfare Plan**:

NAME	BIRTHDATE	RELATIONSHIP	ADDRESS / PHONE #

If more than one beneficiary is designated, settlement will be made in equal shares unless otherwise provided above. If no designated beneficiary survives the member, settlement will be made to the estate of the member.

SECTION 5 – LOCAL 399 DEATH BENEFIT
I designate the same beneficiary for **BOTH** my Health & Welfare death benefit and my Local 399 member death benefit: ❒ YES ❒ NO
If NO, please designate beneficiary below for my LOCAL 399 DEATH BENEFIT only:

NAME	BIRTHDATE	RELATIONSHIP	ADDRESS / PHONE #

I certify that all information provided to the Fund Office on this form is correct and that the beneficiary listed above was designated by me on this date.

_____ Member Name (Please Print)

_____ Signature of Member

_____ / _____ / _____ Member Social Security No.

(_____) _____ Primary Phone Number

_____ Date

Birth Certificate Received: _____ Marriage Certificate Received: _____ Divorce Decree Received: _____ SPD Provided: _____