



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