IBEW Local 613 and Contributing Employers
Family Health Fund

c/o National Employee Benefits Administrators, Inc.
3715 Northside Parkway Suite 2-495 ● Atlanta, GA 30327
2010 N.W. 150th Avenue, Suite 100 ● Pembroke Pines, FL 33028
1.800.922.1613 ● Fax 678.705.0205

Life Benefit *If your death occurs while covered as a Bargaining or Non-Bargaining Employee by the Family Health Plan, the Fund will pay your beneficiary the amount of life coverage in force at the time of your death (please refer to the Schedule of Benefits for coverage amounts). Payment will be made in a lump sum.*

Designated Beneficiary *You may designate anyone you wish as your beneficiary and change the designation at any time by giving written notice to the Fund Office. All designations must be signed and dated. The designation is effective as of the date signed. However, the Fund shall not be liable for payment made prior to the receipt of the designation request. Unless otherwise specified, two or more named beneficiaries shall share equally and the interests of any beneficiary who predeceases you shall terminate and his share shall be payable to any surviving beneficiaries.*

If you do not designate a beneficiary *Any Amount for which there is no beneficiary designation at your death shall be payable at the first surviving class of beneficiaries as follows; (1) widow or widower; (2) surviving child or children; (3) surviving parent or parents; (4) surviving brothers and sisters; (5) executers or administrators.*

NOTE: Any participant and/or beneficiary shall not be eligible for the Life coverage during any period that he or she is paying for COBRA coverage.

1. *Participant Information*

First Name		MI		Last Name	
SSN			Phone Number		

2. *Primary Beneficiary(ies)* *(Unless specific percentages are specified, benefits will be split equally among primary beneficiaries)*

	Beneficiary Name	Relationship	SSN	DOB	% of Benefit
# 1					
Address, City, ST, Zip					
# 2					
Address, City, ST, Zip					
# 3					
Address, City, ST, Zip					
# 4					
Address, City, ST, Zip					

2. *Contingent Beneficiary(ies)* *(If Primary Beneficiaries are not living at time of my death, benefit is to be made to:)*

	Beneficiary Name	Relationship	SSN	DOB	% of Benefit
# 1					
Address, City, ST, Zip					
# 2					
Address, City, ST, Zip					
# 3					
Address, City, ST, Zip					
# 4					
Address, City, ST, Zip					

Participant Signature	*Date*