Southern California United Food & Commercial Workers Unions
and Food Employers Joint Benefit Funds Administration, LLC

6425 Katella Avenue, Cypress, CA 90630-5238
P.O. Box 6010, Cypress, CA 90630-0010
877-284-2320 · **scufcwfunds.com**

Benefits+
Your Trusted Benefits Partner

Death Benefit* Beneficiary Designation with Change

Participant or Retiree Information

Supply all information requested below. Please print clearly.

Last Name	First	Initial	Fund ID OR Social Security #

Street ☐ Check if Mailing Address is new.	Home Phone	Mobile Phone	Date of Birth (mm/dd/yyyy)

City	State	ZIP Code	Email	☐ Active ☐ Retired

I hereby request and authorize the United Food & Commercial Workers Unions and Food Employers Benefit Fund to pay my Death Benefit*, at my death, to the person(s) I have named below. This designation supersedes and renders void all previous designations I have made, and will become effective upon receipt of this form by the Fund Office.

Primary Beneficiary Information 1 of _____

Supply all information requested below. Please print clearly.

Last Name	First	Initial	Social Security #

Street ☐ Check if Mailing Address is new.	Home Phone	Mobile Phone	Date of Birth (mm/dd/yyyy)

City	State	ZIP Code	Relationship To Participant/Retiree

Primary Beneficiary Information 2 of _____

Supply all information requested below. Please print clearly.

Last Name	First	Initial	Social Security #

Street ☐ Check if Mailing Address is new.	Home Phone	Mobile Phone	Date of Birth (mm/dd/yyyy)

City	State	ZIP Code	Relationship To Participant/Retiree

Primary Beneficiary Information 3 of _____

Supply all information requested below. Please print clearly.

Last Name	First	Initial	Social Security #

Street ☐ Check if Mailing Address is new.	Home Phone	Mobile Phone	Date of Birth (mm/dd/yyyy)

City	State	ZIP Code	Relationship To Participant/Retiree

Primary Beneficiary Information 4 of _____

Supply all information requested below. Please print clearly.

Last Name	First	Initial	Social Security #

Street ☐ Check if Mailing Address is new.	Home Phone	Mobile Phone	Date of Birth (mm/dd/yyyy)

City	State	ZIP Code	Relationship To Participant/Retiree

Continue to the back of the form

If you would like to have additional primary beneficiaries, print the beneficiary information requested on the front page for each on a separate sheet of paper. Print your name and last four digits of your Social Security Number on the top of the page and attach it to this form.

Contingent Beneficiary Information

Supply all information requested below. Please print clearly.

A contingent beneficiary receives the death benefit proceeds if the primary beneficiary(ies) dies.

Last Name	First	Initial	Social Security #

Street ☐ Check if Mailing Address is new.	Home Phone	Mobile Phone	Date of Birth (mm/dd/yyyy)

City	State	ZIP Code	Relationship To Participant/Retiree

Trust Beneficiary Information

Supply all information requested below. Please print clearly.

A Trust may be named beneficiary, however payment will be made to the Successor Trustee(s) and not to the trust itself.

Last Name	First	Initial	Social Security #

Street ☐ Check if Mailing Address is new.	Home Phone	Mobile Phone	Date of Birth (mm/dd/yyyy)

City	State	ZIP Code	Relationship To Participant/Retiree

Complete and return this form to **UFCW Benefit Fund, P.O. Box 6010, Cypress, CA 90630-0010**

* The Death Benefit is a health & welfare benefit subject to modification or elimination. It is not a life insurance policy, nor is it vested, non-forfeitable, or guaranteed in any way.

An **Active** participant must have been enrolled in the Plan and eligible, based on hours worked and timely contributions to premium paid, at the time of death, for a Death Benefit to be considered. COBRA Continuation Coverage does not include a Death Benefit.

A **Retiree** must have been eligible and enrolled in the Retiree Medical Plan at the time of death, and has to have made timely payment of any premiums required for coverage, for a Death Benefit to be considered.

Your Signature

You must sign this document in the presence of the following: a fund official, a union official, or a notary public, or have your signature guaranteed by your bank.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

Signature_____Date_____

Phone_____

State of_____, County of_____

Subscribed and sworn to (or affirmed) before me on this _____

Day of _____, 20_____

by _____proved to me on the basis of satisfactory evidence to be the person who appeared before me.

Notary's Signature_____(seal)