IBEW Local No 9 & Line Clearance Contractors Beneficiary Designation Form

Participant Name (Please Print):____

Address:____

____

____

Member Identification Number:____________________ Date of Birth:_______________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

HEALTH CARE BENEFICIARY:

Beneficiary's Name (Please Print:____

Address:____

____

Social Security Number:____________________ Date of Birth:_____________________

Relationship:____

____________________________________ _______________________

Participant's Signature Date

PLEASE RETURN THIS FORM TO:

IBEW Local No 9 & Line Clearance Contractors Health & Welfare Fund
6525 Centurion Drive
Lansing, MI 48917-9275

**If you have any questions, please contact the Fund Office toll free at (877) 423-9155. Office hours are 7:30 a.m. - 5:30 p.m. (Eastern Standard Time)