UNITED WELFARE FUND

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

ACCIDENTAL DEATH AND DISMEMBERMENT

GROUP INFORMATION	
POLICY HOLDER: UNITED WELFARE FUND	GROUP #: 231537

EMPLOYEE INFORMATION

Employee Name (First, Middle, Last)		Social Security #
Date of Birth	Email	Phone
Address	City, State	Zip
Employer		

BENEFCIARY DESIGNATION FOR EMPLOYEE INSURANCE

I designate the following persons(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation, any previous designation of a beneficiary is hereby revoked. I understand that I have the right to change this designation at any time.

Beneficiary Name (First, Middle, Last)		Social Security #	Relationship	Share %
Date of Birth	Email		Phone	
Address	City, State		Zip	
Beneficiary Name (First, Middle, Last)		Social Security #	Relationship	Share %
Date of Birth	Email		Phone	
Address	City, State		Zip	
Beneficiary Name (First, Middle, Last)		Social Security #	Relationship	Share %
Date of Birth	Email		Phone	
Address	City, State		Zip	
Payment will be made in equal shares or all to the survivor unless otherwise indicated				100%
If all the primary beneficiary(ies) die before me, I designate the following as contingent beneficiary(ies):				
Beneficiary Name (First, Middle, Last)		Social Security #	Relationship	Share %
Date of Birth	Email		Phone	
Address	City, State		Zip	
Beneficiary Name (First, Middle, Last)		Social Security #	Relationship	Share %
Date of Birth	Email		Phone	
Address	City, State		Zip	
Payment will be made in equal shares or all to the survivor unless otherwise indicated				100%

SIGNATURE

DATE

PLEASE RETURN FORM TO: UPSEU
3555 Veterans Hwy, Suite H
Ronkonkoma, NY 11779
(631) 738-8773 - FAX: (631) 738-7236

Coverage is effective April 1 following your date of employment and continued membership in UPSEU

UPSEU