PLEASE SUBMIT YOUR COMPLETED BENEFICIARY FORM TO:
UBC Healthcare Trust Fund
P.O. Box 1449
Goodlettsville, TN 37070-1449
Phone: 800-831-4914
Fax: (615) 859-4699

BENEFICIARY DESIGNATION FORM

PARTICIPANT INFORMATION

Name: _____ Soc. Sec. No.: _____

Address: _____

Date of Birth: _____ Local Union No.: _____ Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed

BENEFICIARY DESIGNATION

Primary Beneficiary: _____ Soc. Sec. No.: _____ Relationship: _____

Address: _____

Contingent Beneficiary: _____ Soc. Sec. No.: _____ Relationship: _____

Address: _____

Participant Signature:_____ Date:_____

UBCHBDFORM