



**TRANSPORT WORKERS UNION HEALTH & WELFARE PLAN  
 TRANSPORT WORKERS UNION RETIREMENT & SEVERANCE FUND  
 9411 PHILADELPHIA ROAD, SUITE S ♦ BALTIMORE, MARYLAND 21237-4168**

**Telephone Numbers:**

**Local: 410-444-0659**

**Toll Free: 800-832-8982**

**Fax: 410-444-0035**

**BENEFICIARY DESIGNATIONS FORM**

The purpose of this form is to designate beneficiaries for the life insurance benefit provided through ReliaStar Life Insurance Company.

**Section I – General Information**

Last Name	First Name	Middle Initial	
Social Security Number	Gender	Date of Birth	Union Card Number
Street Address		City, State, Zip	
Home Telephone Number (include area code)		Marital Status (Circle One)	
		Single    Married    Divorced	

**Section II - Beneficiary Designations**

I hereby designate the following people as my beneficiaries for the Transport Workers Union Health & Welfare Plan's life insurance benefit provided through ReliaStar Life Insurance Company.

Name	
Street Address	City, State, Zip
Relationship	Percentage

Name	
Street Address	City, State, Zip
Relationship	Percentage

I hereby make the designation of beneficiary above and revoke any previous designations. I understand that the beneficiaries named above may be revoked at any time by filing a new designation in writing on the Fund office's form. I understand that if all of the above designated beneficiaries predecease me, the distribution will be made in accordance with the terms of the Plan. **I agree to notify the Fund Office immediately of any change in my marital status.**

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

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## Declaration of Health Insurance

Check here if **NO OTHER COVERAGE** available to you, your eligible spouse and/or dependents and sign & date this form at the bottom.

- OR -

If you, your spouse and/or dependent children have other coverage, please complete the form below and return with a copy of the other carrier's identification card.

Other Coverage Carrier Name	Policy Holder's Name	Type of policy (Retiree plan, Active plan etc.)	Effective date
_____	_____	_____	_____

List who is covered and relationship to policy holder	Type of Coverage (Check all that apply)
_____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug

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Other Coverage Carrier Name	Policy Holder's Name	Type of policy (Retiree plan, Active plan etc.)	Effective date
_____	_____	_____	_____

List who is covered and relationship to policy holder	Type of Coverage (Check all that apply)
_____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription Drug

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**Important:** If the other coverage terminates, the Fund requires a copy of the HIPPA notice issued from the other carrier. This notice is required to be mailed upon termination.

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_____	_____	_____	_____
Print Name	Member Signature	Date	SS#