



**Benefit Fund for Hospital & Health Care Employees  
Philadelphia and Vicinity**

1319 Locust Street, Philadelphia, Pa 19107-5405  
(215) 735-5720 • (800) 531-1199 • FAX (215) 985-9232  
<http://www.1199cfunds.org> • [info@1199cfunds.org](mailto:info@1199cfunds.org)

**BENEFICIARY INFORMATION – DEATH BENEFIT**

*Please PRINT all information and SIGN where indicated*

Your name \_\_\_\_\_

Your Social Security Number \_\_\_\_\_ Your date of birth \_\_\_\_\_

Your street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Below, please name the person(s) to whom your Death Benefit is to be paid. Please provide ALL requested information. If your beneficiary is a minor, state her/his age and provide the name(s) of the person's parent(s) or guardian(s) in the "Remarks" section below. You may name more than one person to share the Death Benefit. Should you choose to do this, indicate the percentage each individual is to receive in the "Remarks" section below and indicate that ALL of your named beneficiaries are primary beneficiaries. Any person named as a secondary beneficiary will receive benefits only if the primary beneficiary dies before you.

**PRIMARY BENEFICIARY**

Name of beneficiary \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of birth \_\_\_\_\_  
*No claims can be paid without the beneficiary's SSN and date of birth*

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**SECONDARY BENEFICIARY**

Name of beneficiary \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of birth \_\_\_\_\_  
*No claims can be paid without the beneficiary's SSN and date of birth*

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**REMARKS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your signature \_\_\_\_\_ Today's date \_\_\_\_\_