HOLLOW METAL TRUST FUND
WELFARE & PENSION FUNDS BENEFICIARY DESIGNATION FORM

To designate, revoke, or change a beneficiary, please complete, sign, and date this Beneficiary Designation Form and return the original to the Hollow Metal Trust Fund at 395 Hudson Street 9th Floor New York, NY 10014

Full Name: ______________________ Social Security Number: ______________________

Date of Birth: ______________________ Local Union & UBC#: ______________________

Street Address: ____
City State Zip Code

Home Phone: ______________________ Cell Phone: ______________________

Marital Status: Single ( ) Married ( ) Divorced ( ) Widowed ( )

Email: ______________________ Initiation Date: ______________________

PRIMARY BENEFICIARY INFORMATION: (IF DESIGNATING MORE THAN ONE PRIMARY BENEFICIARY PLEASE USE THE BACK)

Full Name: ______________________ Social Security Number: ______________________

Relationship to you: ______________________ Date of Birth: ______________________

Street Address: ____
City State Zip Code

Home Phone: ______________________ Cell Phone: ______________________

Email: ______________________ % of Benefit: ______________________

CONTINGENT BENEFICIARY INFORMATION: (IF DESIGNATING MORE THAN ONE CONTINGENT BENEFICIARY PLEASE USE THE BACK)

Full Name: ______________________ Social Security Number: ______________________

Relationship to you: ______________________ Date of Birth: ______________________

Street Address: ____
City State Zip Code

Home Phone: ______________________ Cell Phone: ______________________

Email: ______________________ % of Benefit: ______________________

I hereby designate the above named beneficiary(ies) to receive any death benefits or unpaid benefit due upon my death from the Hollow Metal Welfare & Pension Funds. I further understand that beneficiary designations may be changed by me at any time.

Please be aware that this form does not guarantee an assignment of benefits.

Full Signature: ______________________ **Date Signed:** ______________________

Hollow Metal Welfare & Pension Funds
395 Hudson Street 9th Floor
New York, NY 10014

PRIMARY BENEFICIARY INFORMATION:

Full Name: ________________________ Social Security Number: ________________________

Relationship to you: ________________________ Date of Birth: ________________________

Street Address: ____
City State Zip Code

Home Phone: ________________________ Cell Phone: ________________________

Email: ________________________ % of Benefit: ________________________

PRIMARY BENEFICIARY INFORMATION:

Full Name: ________________________ Social Security Number: ________________________

Relationship to you: ________________________ Date of Birth: ________________________

Street Address: ____
City State Zip Code

Home Phone: ________________________ Cell Phone: ________________________

Email: ________________________ % of Benefit: ________________________

CONTINGENT BENEFICIARY INFORMATION:

Full Name: ________________________ Social Security Number: ________________________

Relationship to you: ________________________ Date of Birth: ________________________

Street Address: ____
City State Zip Code

Home Phone: ________________________ Cell Phone: ________________________

Email: ________________________ % of Benefit: ________________________

CONTINGENT BENEFICIARY INFORMATION:

Full Name: ________________________ Social Security Number: ________________________

Relationship to you: ________________________ Date of Birth: ________________________

Street Address: ____
City State Zip Code

Home Phone: ________________________ Cell Phone: ________________________

Email: ________________________ % of Benefit: ________________________

*****Please ensure that the designated percentage of benefits equals to a 100%*****