Middletown Works Hourly & Salaried
Union Retirees Health Care Fund
1201 Crawford Street • Middletown, OH 45044
PH: (513) 217-4818 • TOLL FREE: (877) 392-9991 • Fax: (513) 672-9622

Participant Information

Name (Last, First, MI)	Date of Birth (Month/Day/Year	Social Security No.
Street Address		
City, State, Zip Code		Home Telephone No. ( )
Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Divorced/Legally Separated		Sex ☐ Male ☐ Female

Beneficiary Designation for Death Benefits (effective upon receipt by the Administrative Fund Office)

Primary Beneficiary: Provide information for the primary beneficiary(s) to receive any death benefits from the Middletown Works Hourly and Salaried Union Retirees Health Care Fund (if more than one primary beneficiary is named, the benefit will be divided equally).

1) Primary Beneficiary Name (Last, First, MI)	Relationship	Social Security No.	Date of Birth
Street Address	City	State, Zip Code	Phone Number
2) Primary Beneficiary Name (Last, First, MI)	Relationship	Social Security No.	Date of Birth
Street Address	City	State, Zip Code	Phone Number

Contingent Beneficiary: Provide information for the contingent beneficiary(s) to receive the death benefit in the event that all primary beneficiaries named above die before the benefit is paid (if more than one contingent beneficiary is named, the benefit will be divided equally).

1) Contingent Beneficiary Name (Last, First, MI)	Relationship	Social Security No.	Date of Birth
Street Address	City	State, Zip Code	Phone Number
2) Contingent Beneficiary Name (Last, First, MI)	Relationship	Social Security No.	Date of Birth
Street Address	City	State, Zip Code	Phone Number

Participant Certification

I certify that the information contained on this form is accurate and complete to the best of my knowledge. I hereby revoke all prior beneficiary designations made by me with respect to the Middletown Works Hourly and Salaried Union Retirees Health Care Fund and direct that any benefits payable under the Fund upon my death be paid as designated on this form. **If you are signing on behalf of the participant, please include a copy of the Power of Attorney Documentation with this form.**

Participant or authorized signer's Signature	Date

Return this form to the address listed at the top of the page. If you have any questions regarding this form, contact the Administrative Fund Office toll-free at 877-392-9991.