W F RETIREES' HEALTH TRUST
DEATH BENEFIT COVERAGE BENEFICIARY FORM

MEMBER INFORMATION

Last Name _____ First Name _____ MI _____

Social Security Number __ __ __ - __ __ - __ __ __ __ Date of Birth: ___ / ___ / _____ Effective Date: ___ / ___ / _____ Telephone (____) ____ - _____

Street Address _____ City _____ State _____ Zip Code _____

AUTHORIZATION

I acknowledge and understand that the WF Retirees' Health Trust may request or disclose information about me from time to time for the purpose of facilitating claim payment or for the purpose of business operations necessary to administer death benefits, or as required by law.

Any person who knowingly and with intent to defraud the Health Trust or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I have read the above statements and represent that the information provided is true and complete to the best of my knowledge. I understand that the provision of any false information on this application may result in the termination of my benefits and may subject me to legal action by the Plan Administrator.

Member Signature Date Signed

_____ _____

BENEFICIARY INFORMATION
REQUIRED FOR ALL DEATH BENEFIT ENROLLMENTS

Primary Beneficiary's Last Name _____ First Name _____ MI _____

Relationship of Beneficiary _____ Social Security Number __ __ __ - __ __ - __ __ __ __

Street Address _____ City _____ State _____ Zip Code _____

Contingent Beneficiary's Last Name _____ First Name _____ MI _____

Relationship of Contingent Beneficiary _____ Social Security Number __ __ __ - __ __ - __ __ __ __

Street Address _____ City _____ State _____ Zip Code _____