UNITE HERE HEALTH ALASKA

Life insurance beneficiary form

Return completed form to: UNITE HERE HEALTH, 5655 Badura Ave, Ste 180, Las Vegas, NV 89118
Fax: 702-473-8109 | **Email:** UNITEHEREAppeals@zenith-american.com

1: Employee information

Last Name	First	Middle	Date of Birth (month-day-year)	Gender
				☐ Male ☐ Female

Street	Apt #	Telephone	Cell Phone
		( )	( )

City	County	State	Zip	Social Security #	Email
				- -	

2: Primary life insurance beneficiaries

If you name more than one primary beneficiary but leave "Share of Benefit" blank, they will share the benefit equally. If one of them dies before you do, his/her share will be divided equally between the other primary beneficiaries (unless you say otherwise). The same rules apply to your secondary beneficiaries. *If you need to add more beneficiaries, use another piece of paper.*

All shares must add up to 100%

Name	Relationship	Social Security # *(if available)*	Date of Birth	Share of Benefit
		- -		%
Address			Phone #	
Name	Relationship	Social Security # *(if available)*	Date of Birth	Share of Benefit
		- -		%
Address			Phone #	
Name	Relationship	Social Security # *(if available)*	Date of Birth	Share of Benefit
		- -		%
Address			Phone #	
Name	Relationship	Social Security # *(if available)*	Date of Birth	Share of Benefit
		- -		%
Address			Phone #	

3: Secondary life insurance beneficiaries

Please list who you want to receive your life insurance benefit in the event your primary beneficiary(s) listed above do not survive you.

Name	Relationship	Social Security # *(if available)*	Date of Birth	Share of Benefit
		- -		%
Address			Phone #	
Name	Relationship	Social Security # *(if available)*	Date of Birth	Share of Benefit
		- -		%
Address			Phone #	
Name	Relationship	Social Security # *(if available)*	Date of Birth	Share of Benefit
		- -		%
Address			Phone #	

4: Signature

Coverage is dependent upon the Plan's eligibility requirements and all Plan benefits are subject to the rules adopted by the Board of Trustees of UNITE HERE HEALTH. This form replaces all previous beneficiary designations and must be signed and dated to be valid; it will not become effective until received by UNITE HERE HEALTH.

Print Name ______________________________

Signature ______________________________ Date ______________

02/2024