Ohio Bricklayers' Health & Welfare Fund

Designation or Change of Beneficiary

Participant Name: _____ Social Security #: _____

Address: _____
Number and Street Name City State Zip

Pursuant to the provisions of the Plan, I hereby designate the person or persons named below as my beneficiary or beneficiaries to receive, in the event of my death, any amounts payable as a death benefit under the Plan.

I certify that I am: _____ Unmarried _____ Married

Name of Beneficiary: _____ Relationship: _____

Address: _____
Number and Street Name City State Zip

Social Security #: _____ Date of Birth: _____

Additional Beneficiaries: _____
(If any)
_____

Signature of Participant: _____ Date: _____