INSURANCE & PENSION FUNDS OF ROOFER'S LOCAL #241

Fund Participant Information & Beneficiary Designation Form

This form is used to protect your Insurance and Pension benefits. Please complete all applicable sections and sign where indicated. Incomplete or unsigned forms may delay benefit payments.

Participant Information

Full Legal Name:
Date of Birth (MM/DD/YYYY):
Social Security Number:
Home Address:
City / State / ZIP:
Email address:
Cell Phone:

Marital Status:

☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse Information (Complete only if married)

Spouse Full Name:	
Spouse Date of Birth:	
Spouse SSN:	
Date of Marriage:	
Employer Name (if applicable):	
Insurance Carrier (if applicable):	

Dependent Information (Under age 26)

Attach proof of parental or legal guardianship.

Name	Date of Birth	SSN	Relationship

Medical Benefit Beneficiary Designation

This designation replaces all previous medical beneficiary designations.

Primary Beneficiary Name:	
Relationship:	
Contingent Beneficiary Name:	
Relationship:	

Pension Plan Beneficiary Designation

This designation replaces all previous pension beneficiary designations.

Primary Beneficiary Name:	
Relationship:	
Contingent Beneficiary Name:	
Relationship:	

Participant Signature: _____ Date: _____

Witness Signature: _____ Date: _____