Heartland
HEALTH & WELLNESS FUND

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BENEFICIARY FORM

Please complete, sign and return this form to the Plan Office. Please print all information.

Employee Information (Please Print):

Employee Full Name: _____ Employee SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

E-mail address (if applicable): _____

Home Phone #: _____ Home/Cell Phone #: _____ Date of Birth: _____

Sex: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Current Employer: _____ Employer Phone Number: _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Beneficiary Designation for Death Benefits – Designations are effective upon receipt by Plan Office

Primary Beneficiary(ies): I, the undersigned, hereby revoke any and all prior beneficiary designations made by me with respect to the Heartland Health & Wellness Fund (the "Benefit Plan") and hereby direct that any benefits payable under the Benefit Plan upon my death be paid to the following primary beneficiary (or equally to the following primary beneficiaries). This beneficiary designation is effective when received by the Benefit Plan Office.

Name	Social Security #	Relationship	Address

Contingent Beneficiary(ies): In the event all of the above named beneficiaries die or disclaim benefits before the full amount of benefits, if any, has been paid, I direct that my entire remaining interest in the Benefit Plan be paid to the following contingent beneficiary (or equally to the following contingent beneficiaries). This contingent beneficiary designation is effective when received by the Plan Office.

Name	Social Security #	Relationship	Address

Employee Certification: I hereby certify that the foregoing information, to the best of my knowledge and belief, is true, correct and complete. I understand any willfully false statement on this form is a federal crime that is punishable by fine or imprisonment.

Employee's Signature: _____ Date: _____