

REQUEST FOR LIFE BENEFIT

CARPENTERS HEALTH AND SECURITY TRUST OF WESTERN WASHINGTON

PROOF OF DEATH

To be completed and mailed along with a certified copy of DEATH CERTIFICATE to:

Claims Department Carpenters Health and Security Trust of Western Washington P.O. Box 1929 Seattle, Washington 98111

TO BE COMPLETED BY LIFE INSURANCE BENEFICIARY:

Full Name of Deceased _____ S.S. # _____
Address _____ Participant
City, State, Zip _____ Spouse
Date of Birth _____ Date of Death _____ Dependent

TO BE USED ONLY WHEN DEATH IS THE RESULT OF ACCIDENT

Date of Accident: _____	Place of Accident: _____	Did Accident Occur In Course of Employment? _____
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How Did Accident Occur? _____

Signature of Beneficiary _____ S.S. # _____
Address of Beneficiary _____ Relationship _____
City, State, Zip _____ Telephone # _____
Date Signed _____ Beneficiary's Date of Birth _____

If the benefit is payable to the estate, executors or administrators of the Insured, the Statement of Beneficiary must be completed by the executor or administrator, a certificate of whose appointment and qualification must be attached. If proceeds are payable to a minor, statement must be made by a guardian and an official certificate of the guardian's appointment and qualification must be submitted to the Claims Department.

FOR ADMINISTRATIVE USE ONLY: Certificate of Eligibility

This is to certify that _____
was eligible _____
Date _____ Month _____ Year _____

CARPENTERS HEALTH AND SECURITY TRUST OF WESTERN WASHINGTON

Larry P. McNutt, Administrator