KENTUCKY LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND

1996 Bypass South
Lawrenceburg, KY 40342

Telephone: (502) 839-8166 **Fax: (502) 839-3558**

AFFIDAVIT OF SURVIVORSHIP

PARTICIPANTS FULL NAME:	PARTICIPANTS SOC. SEC. #:	PARTICIPANTS DATE OF DEATH:

WE HEREBY CONFIRM THAT THE FOLLOWING IS A COMPLETE LIST OF THE FAMILY MEMBERS (SPOUSE, MOTHER, FATHER, CHILDREN, SISTERS, AND/OR BROTHERS) OF THE ABOVE-REFERENCED PARTICIPANT:

FULL NAME (First, Middle Initial, Last)	SOCIAL SECURITY NUMBER	RELATIONSHIP TO PARTICIPANT	DATE OF DEATH (IFAPPLICABLE)

If there are more family members (spouse, mother, father, children, sisters, and/or brothers) than listed above, please use reverse side of form to provide requested information for those persons

THEREFORE, WE, THE SURVIVING FAMILY MEMBERS LISTED ABOVE (AND ON REVERSE SIDE OF FORM IF APPLICABLE), DECLARE THAT WE ARE SOLE BENEFICIARIES FOR ANY LIFE BENEFITS PAYABLE THROUGH THE KENTUCKY LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND AND WE CONFIRM THAT ALL INFORMATION GIVEN HEREIN IS TRUE AND CORRECT.

BENEFICIARYS SIGNATURE	BENEFICIARYS ADDRESS (Street or P.O. Box, City, State, Zip)

Witnessed By: _____

Signature of Notary Public

_____

Street or P.O.Box **City** **State** **Zip**

(Affidavit of Survivorship - Additional Family Members)

FULL NAME (First, Middle Initial, Last)	SOCIAL SECURITY NUMBER	RELATIONSHIP TO PARTICIPANT	DATE OF DEATH (IFAPPLICABLE)

BENEFICIARYS SIGNATURE	BENEFICIARYS ADDRESS (Street or P.O. Box, City, State, Zip)