

**SOUTHERN & CENTRAL ILLINOIS LABORERS' VACATION FUND**

**BENEFICIARY FORM**

5100 Ed Smith Way, Suite A  
Marion, IL 62959  
618-998-1300 fax # 618-997-9063  
[www.silehw.org](http://www.silehw.org)

**MEMBER INFORMATION**

**PLEASE PRINT**

Last Name		First	Middle Initial
Mailing Address		City	State Zip
Soc Sec #	Contact Phone #	Email	
<input type="checkbox"/> Single	Birthdate	Local Union #	
<input type="checkbox"/> Married			

**PRIMARY BENEFICIARY (Individual to receive benefit in the event of your death; cannot be member)**

Last Name		First	Middle Initial
Mailing Address		City	State Zip
Soc Sec #	Birthdate	Relationship	Contact Phone #

**SECONDARY BENEFICIARY (Individual to receive benefit in the event of your death; cannot be member)**

Last Name		First	Middle Initial
Mailing Address		City	State Zip
Soc Sec #	Birthdate	Relationship	Contact Phone #

_____ Signature		_____ Date
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**Please contact the Vacation Fund Office in writing if there is any change in address, marital status & or beneficiary**

**RETURN INFORMATION OPTIONS**

MAILING ADDRESS  
SOUTHERN ILLINOIS LABORERS' & EMPLOYERS' HEALTH & WELFARE FUND  
5100 ED SMITH WAY, SUITE A  
MARION, IL 62959  
FAX: 618-997-9063  
EMAIL INFORMATION TO: [enrollment@silehw.org](mailto:enrollment@silehw.org)  
OFFICE # 618-998-1300