

WEST VIRGINIA LABORERS TRUST FUND

PLAN OFFICE
WEST VIRGINIA LABORERS TRUST FUND
ONE UNION SQUARE
SUITE 200
CHARLESTON, WV 25302

Phone: (304) 342-5142
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BENEFICIARY'S STATEMENT PROOF OF DEATH

Section I: Beneficiary Information

Name: _____ Soc. Sec. No: _____
Address: _____ Birth Date: _____
City: _____ State: _____ Zip Code: _____ Telephone: _____

Section II: Participant Information

Name: _____ Soc. Sec. No: _____
Birth Date: _____ Date of Death: _____ Death Certificate? YES NO
Local Union No: _____ Date of last employment: _____ Last employer: _____

Section III: Accidental Death Claim

Complete this section only if you are filing a claim for Accidental Death Benefits.

Date of Accident: _____ Location of Accident: _____

Did the accident arise out of or occur in the course of employment? YES NO

Describe how the accident occurred and the nature of the injuries (include attachments if more space needed):

Section VII: Beneficiary Signature and Certification

I hereby certify that the information furnished above is true and correct to the best of my knowledge, and I hereby authorize all actions necessary to implement the elections made above. I understand that all payments are governed by the document for the Profit Sharing Plan and that I must hold any payments not provided for in the document for the benefit and reimbursement of the Plan.

Signature: _____ Date: _____
(Sign in Presence of Notary Public)

State of: _____ County of: _____ On _____, 20____, the above-named Beneficiary appeared before me and signed this Application for Death Benefit.

[SEAL]

Notary Public: _____

Commission Expires: _____

Section VIII: Plan Office Use Only

- A. Application and Instructions mailed delivered to Beneficiary on _____ by _____
- B. Application received from Beneficiary on _____ by _____
- C. Distribution approved / denied on _____ by _____
- D. Check issued on _____ by _____