HARRY LACKHOVE POST 517 DEATH BENEFIT
BENEFICIARY CLAIM

Post Member's Name _____

Address _____
Street City State Zip

_____
Phone Number Email Address

MY BENEFICIARY (Person to be paid at death)

_____
First Name Initial Last Name

_____
Address

_____
Phone Number Email Address

I Understand that no benefits will be paid if current dues are not paid.

Date _____ **Sign Your Name Here** _____