Carewell SEIU503

Training. Health. Support.

Carewell SEIU 503 is the family of training and benefits hardwon by SEIU 503 homecare and personal support providers to enhance their lives. Delivered clearly, easily and reliably, this offers the stability, health, skills and training workers deserve.

All training and benefits are delivered by RISE Partnership, a worker centered support service.

525 NE Oregon Street
Portland, OR 97232

Phone 1-844-503-7348
Fax 1-866-459-4623
Web carewellseiu503.org
Email carewellSEIU503benefits@RISEpartnership.com

Paid Time Off Benefit Designation of Beneficiary Form

Form ID: PTO2-1221-E

Please complete this Designation of Beneficiary Form applicable to your Carewell SEIU 503 Paid Time Off benefits. You may designate one primary beneficiary, as well as one contingent beneficiary who will receive any available benefit in the event that your primary beneficiary predeceases you. Please provide the full name of your designated beneficiaries, as well as their addresses and their relationships to you.

Section 1. Primary Beneficiary.
By my signature below, I hereby designate the following individual as my Primary Beneficiary for the purpose of receiving any Carewell SEIU 503 Paid Time Off benefit payable on my behalf in the event of my death. Further, I hereby revoke any prior designation of Primary Beneficiary. I understand that this beneficiary designation will become effective only upon its receipt by the Benefits Administrative Office.

Last name _____ First name _____ Relationship _____

Street Address _____ City _____ State _____ Zip Code _____

Email _____ Phone number _____

Section 2. Contingent Beneficiary.
By my signature below, I hereby designate the following individual as my Contingent Beneficiary for the purpose of receiving any Carewell SEIU 503 Paid Time Off benefit payable on my behalf in the event of my death, provided the Primary Beneficiary named above also is deceased. Further, I hereby revoke any prior designation of Contingent Beneficiary. I understand that this beneficiary designation will become effective only upon its receipt by the Benefits Administrative Office.

Last name _____ First name _____ Relationship _____

Street Address _____ City _____ State _____ Zip Code _____

Email _____ Phone number _____

I understand that if none of the beneficiaries designated above survive me, any Paid Time Off benefit remaining upon my death will be paid to the executor of my estate.

Name _____ Provider number _____

Signature _____ Date (mm/dd/yyyy) _____

Please complete this form online, or fax or mail this form and supporting documents to:

Mail: Benefits Administrative Office, PO Box 6, Mukilteo, WA 98275
Fax: 1-866-459-4623
Email: OHCWTPTO@vimly.com Subject: OHCWT PTO
Phone: 1-844-507-7554 Option 3, then select Option 2