

# SOLANO-NAPA COUNTIES ELECTRICAL WORKERS TRUST FUNDS

P.O. Box 1306 ♦ San Ramon, CA 94583 ♦ (925) 208-9980

EMPLOYEE LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE NAME: \_\_\_\_\_

SOCIAL SECURITY NO: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CURRENT MARITAL STATUS (PLEASE CHECK ONE): ☐ MARRIED ☐ NEVER MARRIED ☐ DIVORCED ☐ DIVORCED & REMARRIED ☐ WIDOW(ER)

SPOUSE'S NAME (IF LEGALLY MARRIED): \_\_\_\_\_ DATE OF MARRIAGE: \_\_\_\_\_

SPOUSE'S SOCIAL SECURITY NO: \_\_\_\_\_ IF DIVORCED OR SEPARATED, GIVE DATE: \_\_\_\_\_

**If you are divorced or have ever been divorced, you must submit a copy of your Final Judgment(s) of Dissolution of Marriage along with the Property Settlement(s).**

PREVIOUS SPOUSE'S NAME: \_\_\_\_\_ LAST KNOWN ADDRESS: \_\_\_\_\_

LIST FIRST NAMES AND DATES OF BIRTH FOR ALL DEPENDENT CHILDREN: \_\_\_\_\_

LIST ANY OTHER DEPENDENTS AND RELATIONSHIPS: \_\_\_\_\_

## EXPLANATION REGARDING DESIGNATION OF BENEFICIARY

You may designate the same person to receive all types of benefits named on the lower portion of this form, or different persons to receive each of them. If you list more than one beneficiary, they shall share equally in the applicable benefits. You also may designate a contingent beneficiary to receive benefits if your primary beneficiary(ies) should die. If you do not designate anybody, then applicable benefits will be payable as provided under the Plans. If you are married, your spouse is your beneficiary unless you have designated another person and your spouse has completed the spousal consent section on the bottom of this form. Your spouse's consent must be witnessed by a notary. **IF YOUR MARRIAGE IS DISSOLVED, ANY DESIGNATION OF YOUR SPOUSE AS BENEFICIARY PRIOR TO THE DIVORCE IS AUTOMATICALLY REVOKED.**

**BE SURE TO COMPLETE THE ENTIRE FORM AND RETURN TO THE TRUST OFFICE.**

## BENEFICIARY DESIGNATION

I, \_\_\_\_\_, Social Security No. \_\_\_\_\_ do hereby designate the following named person or persons as my beneficiary or beneficiaries to receive any monies that may be payable by reason of my death, under Solano-Napa Counties Electrical Workers Benefit Pension Fund, Solano-Napa Counties Electrical Workers Health Care and Solano-Napa Counties Electrical Workers Profit Sharing Plans.

1. **PENSION PLAN:** If I should die before retirement, or after retirement but before receiving the fully guaranteed number of monthly benefit payments, pay any applicable benefit to my primary beneficiary(ies) listed below, or to my contingent beneficiary if my beneficiary(ies) dies(s):

PRINT NAME OF BENEFICIARY: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PRINT NAME OF BENEFICIARY: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CONTINGENT BENEFICIARY: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

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## SOLANO-NAPA COUNTIES ELECTRICAL WORKERS TRUST FUNDS

2. **HEALTH CARE PLAN:** Pay group death benefits, if applicable to:

PRINT NAME OF BENEFICIARY: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PRINT NAME OF BENEFICIARY: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CONTINGENT BENEFICIARY: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

3. **PROFIT SHARING PLAN:** In the event of my death, pay any applicable benefits to:

PRINT NAME OF BENEFICIARY: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PRINT NAME OF BENEFICIARY: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CONTINGENT BENEFICIARY: \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

Date \_\_\_\_\_ Signature: \_\_\_\_\_

**SPOUSAL CONSTENT –SPOUSE’S SIGNATURE MUST BE NOTARIZED IF A PERSON OTHER THAN YOUR SPOUSE IS NAMED AS THE BENEFICIARY**

I, \_\_\_\_\_, swear that I am the legal spouse of the employee described on the opposite side. I hereby consent to my spouse naming the beneficiary listed on the reverse side of this card to receive my spouse’s benefit. If my spouse dies before retirement and before my spouse qualifies for early retirement, I understand by this consent that I cannot unilaterally revoke this designation and that I will not be paid a survivor’s benefit.

DATE: \_\_\_\_\_ Spouse’s Signature: \_\_\_\_\_ Spouse’s Social Security No.: \_\_\_\_\_

State of \_\_\_\_\_ County of: \_\_\_\_\_

On \_\_\_\_\_ before me, \_\_\_\_\_, personally appeared \_\_\_\_\_,

DATE NAME, TITLE OFFICER –E.G; “JANE DOE, Notary Public

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument, the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of \_\_\_\_\_ that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

\_\_\_\_\_  
SIGNATURE OF NOTARY

THE INFORMATION REQUESTED ON THIS CARD MUST BE COMPLETE AND THEN BE ON FILE WITH THE FUND’S ADMINISTRATOR. PLEASE RETURN TO:

**SOLANO-NAPA COUNTIES ELECTRICAL WORKERS PENSION PLAN**

**P.O. BOX 1306, SAN RAMON, CA 94583**