

# IBEW LOCAL UNION 306 PENSION ANNUITY FUND

PH. (330) 779-8866

3660 STUTZ DR. STE. 101, CANFIELD, OH 44406

FX. (330) 270-3582

## Beneficiary Election Form

Member's Name \_\_\_\_\_ SS # \_\_\_\_\_

Address \_\_\_\_\_ Phone# \_\_\_\_\_

Birthdate \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_

Below please indicate the person(s) you wish to name as beneficiary(ies) of any death benefits through the above listed Pension Annuity Fund.

Note: If you are legally married at the time of your death Federal law and the Pension Annuity Fund require that benefits be paid to your surviving spouse, unless your spouse consents to the payment of the benefit to someone else. To make that type of change, the Pension Annuity Fund will require a notarized statement from your spouse – see bottom of form for notarized consent by your spouse.

### Beneficiary Designation

Primary Beneficiary \_\_\_\_\_ Percentage of benefit\*\* \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Primary Beneficiary \_\_\_\_\_ Percentage of benefit\*\* \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

\*\*(PLEASE NOTE: THE TOTAL PERCENTAGE OF BENEFIT FOR PRIMARY BENEFICIAIES LISTED MUST EQUAL 100%)

In the event your Primary Beneficiary(ies) pre-deceases you, the below listed Contingent Beneficiary(ies) will be paid based on the percentages you indicate.

Contingent Beneficiary \_\_\_\_\_ Percentage of benefit\* \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Contingent Beneficiary \_\_\_\_\_ Percentage of benefit\* \_\_\_\_\_

SS# \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

\*(PLEASE NOTE: THE TOTAL PERCENTAGE OF BENEFIT FOR ALL CONTINGENT BENEFICIAIES MUST EQUAL 100%)

(Attach additional paper if necessary—please ensure that you indicate “primary” or “contingent” and percentage.)

I understand that this beneficiary designation cancels any previous designation I may have made and will be effective when received in the Fund office and only if **received** prior to my death. Further, I understand that this designation shall be cancelled if my current marriage ends and I remarry, which would make my legal spouse at the time of my death my new primary beneficiary.

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

### Spousal consent of alternate beneficiary designation as noted above (Notary or Plan Rep. Required):

I hereby consent to my spouse's designation of the above beneficiary for death benefits payable through this Fringe Benefit Fund. I fully understand that by signing below, I will not be eligible for the receipt of the benefits payable on behalf of my spouse in the event of his or her death.

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

Subscribed to and sworn to before me, this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public Signature \_\_\_\_\_

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

My Commission expires: \_\_\_\_\_

Notary Stamp / Seal  
Here

Plan Representative \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

(Plan Representative Line for Benefit Office Use Only.)

