

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 401(k) Wage Reduction Retirement Plan.

Note: If you are legally married at the time of your death Federal law and the 401(k) Wage Reduction Retirement Plan 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 401(k) Wage Reduction Retirement Plan 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.)

