

IBEW LOCAL 540 SECURITY PLAN

PH. (330) 779-8854 3660 STUTZ DR. STE. 101, CANFIELD, OH 44406 FX. (330) 270-0912

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 Security Plan.

Note: If you are legally married at the time of your death Federal law and the Security 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 Security 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:

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: \_\_\_\_\_

