IBEW LOCAL NO. 595 TRUST FUNDS

P.O. Box 3420
San Ramon, CA 94583

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 IBEW Local 595 Defined Benefit Pension Plan, IBEW Local 595 Health Care and IBEW Local 595 Money Purchase Pension Plan.

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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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. **MONEY PURCHASE PENSION 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.