



# WESTERN WASHINGTON PAINTERS PENSION TRUST

## Beneficiary Election Form

Participant Name \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Spouse Name \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

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

**Note:** If you are legally married at the time of your death Federal law and the Pension 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 Pension Plan will require a notarized statement from your spouse – see bottom of form for notarized consent by your spouse.

## Beneficiary Designation

If you would like to designate multiple Primary beneficiaries, please attach an additional paper with the information below for each beneficiary.

Primary Beneficiary \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

Contingent Beneficiary(ies) would receive benefits ONLY if there is no Primary Beneficiary(ies) living at the time death benefits become payable

Contingent Beneficiary \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

Percentage of benefit \_\_\_\_\_

Contingent Beneficiary \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ Relationship \_\_\_\_\_

Percentage of benefit \_\_\_\_\_

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.

Participant 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 the Plans. 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 Name \_\_\_\_\_ SSN \_\_\_\_\_

Spouse Signature \_\_\_\_\_ Date \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY NOTARY PUBLIC:**

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

On \_\_\_\_\_, before me, \_\_\_\_\_, personally  
DATE NAME, TITLE OFFICER – E.G., "JANE DOE, Notary Public"

appeared \_\_\_\_\_ who

proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribe to the within instrument and acknowledge 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

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