

# OMAHA CONSTRUCTION INDUSTRY PENSION FUND

P.O. Box 30750 • Salt Lake City, UT 84130 • Phone 402-951-7900 • Toll Free 855-624-7586 • Fax 402.802.9179

## Beneficiary Designation Form

Member's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

DOB: \_\_\_\_\_

**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 designate a non-spouse beneficiary, the Pension Plan will require a notarized statement from your spouse – see bottom of form for notarized consent by your spouse.

### **Beneficiary Designation**

Name of Primary: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

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

Name of Contingent: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_

Relationship: \_\_\_\_\_ Percentage of benefit: \_\_\_\_\_

Name of Contingent: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_

Relationship: \_\_\_\_\_ Percentage of benefit: \_\_\_\_\_

(Attach additional paper if necessary)

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 Primary 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: \_\_\_\_\_