RHODE ISLAND CARPENTERS BENEFIT FUNDS
14 Jefferson Park Road
Warwick, RI 02888
(401) 467-6813 or (401) 467-6816 fax

Beneficiary Election Form

Member's Name_____ SS # _____

Address _____

Spouse's Name _____ SS# _____

Below please indicate the person(s) you wish to name as beneficiary(ies) of any death benefits through the Benefit Funds.

Note: If you are legally married at the time of your death Federal law and the Benefit Funds 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 Benefit Funds 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# _____ Relationship _____
Address_____

Primary Beneficiary _____ Percentage of benefit _____
SS# _____ Relationship _____
Address_____

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# _____ Relationship _____
Address_____

Contingent Beneficiary _____ Percentage of benefit _____
SS# _____ Relationship _____
Address_____

(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: _____