



UA Local 190 Fringe Benefit Funds
P.O. Box 328 • Troy, MI 48099
Toll Free Phone (888) 390-7473 ext. 3 • Fax (248) 918-2979
www.ua190benefits.org

TO: All members of the UA Local 190 Fringe Benefit Funds
RE: Vital Form/Beneficiary Forms & Participant Website Announcement
DATE: July 2025

Dear Member,

Enclosed are a series of important forms to be completed and returned by you and an exciting announcement regarding UA Local 190's new Participant website.

Vital Form

Completion of these forms allows the Benefit Office to process benefits properly and timely. If there are any changes to your information, please note them on the Vital Information Form. If nothing has changed, sign, date and return the form. The Vital Information Form must be returned **even if nothing has changed**. A return envelope has been included for your convenience, or you can return it electronically to enrollmentdocs@benesys.com

This form needs to be completely filled out and returned to the Fund office. The front of the form is for the employee's personal information and dependent information. The back of the form is for other insurance information. **Both sides of the form must be completed.**

MetLife Beneficiary Form – This form designates a beneficiary for your Life Insurance Benefits. Please complete, sign and return this form

Empower 401k Beneficiary Form – This form designates a beneficiary for your 401k benefit Plan. Please complete and return all three pages of this form

Defined Benefit Pension Beneficiary Form – This form designates a beneficiary for your Defined Benefit Pension Plan. Please compete and return this form

Participant Website Announcement

The Trustees of the UA Local 190 Fringe Benefit Funds are pleased to announce a new enhanced member benefit website, www.UA190Benefits.org. This website has been fully updated to provide you with more effective ways to access and manage your benefits. Below is a brief list of items the Participant site can be used for. Please read the enclosed notice for more information.

- Review your Healthcare Eligibility
- Update Vital Form and Beneficiary Info
- Upload Documents
- Make a self-payment via ACH – **COMING SOON!**
- Review your Pension History



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- Review your Pension Check Information
- Review your Annuity Benefits
- Review your SUB Benefits
- Estimate your Pension Benefit via the Pension Estimator: **COMING SOON!**

If you have any questions regarding your benefits or the enclosed, contact the UA Local 190 Benefit Office at (888) 390-7473

Sincerely,
UA Local 190 Benefit Office

Enclosures:

• Vital Information Form	Empower 401K Beneficiary Form
• MetLife Beneficiary Form	Pension Plan Beneficiary Form



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VITAL INFORMATION FORM

Email Completed Documentation: enrollmentdocs@benesys.com

New Hire Enrollment

Adding Dependent(s)

Demographic Change(s)

MEMBER Information: (Please Print)

Last: _____ First: _____ Middle: _____

Address/City/State/Zip: _____

Social Security Number: _____ - _____ - _____ Phone Number: (_____) _____ Cell/Home _____

Date of Birth: _____ / _____ / _____ Gender: (circle one) Male Female

Marital Status: (circle one) Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: _____

Current Status: (circle one) Active Retired Disabled COBRA

Email Address: _____ Alternate Phone Number: _____

Medicare Claim Number: (This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)

Dependent #

Member # _____ Spouse # _____ & Name _____

DEPENDENTS: - Include Spouse (If additional space is needed, please use 2 nd sheet, be sure to include marriage certificate and birth certificates, please see dependent coverage letter)			
FULL NAME	RELATION	BIRTH-DATE	SOCIAL SECURITY NUMBER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

***Dependent children will remain eligible until the age of 26.*

BENEFICIARY(ies): (Death Benefits - Empower, Pension, & MetLife,)

If a minor is named as beneficiary, insurance proceeds can only be paid to a legally appointed/qualified guardian.

Please complete the enclosed three beneficiary forms:

- DC Plan - Empower Beneficiary Form
- Pension Plan - Pension Beneficiary Form
- MetLife Beneficiary Form

(OVER)

OTHER INSURANCE INQUIRY

Signature Required Below

Please complete this portion of the form if you, your spouse, or any of your dependents have other insurance coverage that you participate in, or if there has been any change in other insurance coverage.

General Information:

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Other Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Phone #: (_____) _____

Policy/Group Number: _____

Effective date of coverage: _____ Is insurance active? _____

Termination date if applicable: _____

Coverage is: (circle one) Single Family

Children are covered until age: _____

Type of coverage: (circle all that apply) Medical Dental Vision Prescription

List covered dependents: _____

Coverage provides minimum value under the PPACA: (circle one) Yes No

Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

I understand that if I make a false statement or materially misrepresent the information on this form, my coverage may be retroactively cancelled. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of any acts of fraud or material misrepresentation.

I Have No Other Insurance (Initial): _____

Member Signature: _____

Date: _____



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DEPENDENT COVERAGE

Please read the following information carefully! This letter explains the necessary requirements and documentation needed to add dependents to your health care coverage. Please refer only to the situation which applies to you and provide the required documentation to the Benefit Office.

SPOUSE - Coverage for a spouse can be provided for any eligible active participant. You are required to complete a Vital Information Form for the purpose of verifying any other active insurance coverage. When adding a new spouse to your policy a copy of your marriage certificate and birth certificate is required before coverage will be activated.

CHILDREN - The active participants' natural dependent children and legally adopted children are eligible to be added to your policy. When adding eligible dependents to your policy a copy of each child's birth certificate is required before coverage will be activated. For adopted children please include a copy of the adoption papers.

STEPCHILDREN – Please be advised stepchildren are not automatically eligible dependents. If you are 100% responsible for the stepchildren, and their non-custodial parent has relinquished all legal claims and rights to said children, please forward the child's birth certificate.

DEPENDENTS AGE 19 – 26 - In accordance with the Patient Protection and Affordable Care Act (PPACA also known as Healthcare Reform) health care plans that offer coverage for dependent children must provide coverage for adult children of covered employees until the age of 26. It is no longer a requirement that a dependent child over the age of 19 be a full-time student. Therefore, your children may be eligible for coverage until they attain age 26, regardless of; their student or marital status; whether your home is their principal place of residence or whether you support them. A copy of the child's birth certificate must be sent in before coverage will be activated.

Important: Do not send the original stamped document as it will not be returned to you.
Please submit legible photos or copies of the required documentation.



Group Term Life Insurance Beneficiary Designation

- This form **MUST** be signed before you return it. See "SECTION III – Signature" on page 3.

SECTION I - Insured Information

Customer Number	Employer Name/Group Policyholder Name		
First Name	Middle Name	Last Name	
Address – Street	City	State	ZIP Code
Date of Birth	Phone Number ()	SSN	

SECTION II - Beneficiary Information

- You **MUST** designate at least one primary beneficiary. **A person may only be listed once.** Anyone listed in the primary section cannot be listed in the contingent section.
- The sum of the Primary Beneficiary percentages **MUST equal 100%.** The sum of the Contingent Beneficiary percentages **MUST equal 100%.** Dollar amounts, fractions and decimals will not be accepted.
- If you need more space for additional beneficiaries, attach a separate page. Include all beneficiary information, and sign/date the page.

Please complete the section that pertains to the type of beneficiary you are designating.

A. Individual Beneficiaries

PRIMARY BENEFICIARY - Your first choice to receive your life insurance proceeds in the event of your death. If any primary beneficiaries predecease you, that person's share will be equally divided among any remaining primary beneficiaries.

First Name	Middle Initial	Last Name		Share: %	
Address – Street	City		State		ZIP Code
Relationship to Employee	Social Security Number	Date of Birth	Phone Number ()		
First Name	Middle Initial	Last Name		Share: %	
Address – Street	City		State		ZIP Code
Relationship to Employee	Social Security Number	Date of Birth	Phone Number ()		
First Name	Middle Initial	Last Name		Share: %	
Address – Street	City		State		ZIP Code
Relationship to Employee	Social Security Number	Date of Birth	Phone Number ()		

CONTINGENT BENEFICIARY - Your second choice to receive your life insurance proceeds if ALL of your primary beneficiary(ies) are not living at the time of your death. If any contingent beneficiaries predecease you, that person's share will be equally divided among any remaining contingent beneficiaries.

First Name	Middle Initial	Last Name		Share: %	
Address – Street	City		State		ZIP Code
Relationship to Employee	Social Security Number	Date of Birth	Phone Number ()		

First Name	Middle Initial	Last Name		Share: %	
Address – Street	City		State		ZIP Code
Relationship to Employee	Social Security Number	Date of Birth	Phone Number ()		

B. Living Trust – Primary Contingent

If this form is executed by the insured, it is understood and agreed that if MetLife receives satisfactory proof that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the insured's Estate, unless otherwise indicated on this form.

Trust Name	Trust Date	Trustee Phone Number ()		Share: %
Trustee - First Name	Middle Initial	Last Name		
Trustee Address – Street	City	State	ZIP Code	

C. Testamentary Trust Created in the Insured's Will – Primary Contingent

The trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

				Share: %
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D. Insured's Estate – Primary Contingent

If the Insured's Estate is selected as the Primary Beneficiary, no Contingent Beneficiary may be named.

E. Charity/Organization – Primary Contingent

Be sure to name the charity or organization and not the charity or organization director or an employee of that charity/organization.

Charity/Organization Name		Phone Number ()		Share: %
Address – Street	City	State	ZIP Code	

SECTION III - Signature

Check if you are completing and signing this form as agent for the employee under a valid Power of Attorney. Return a copy of the Power of Attorney with this beneficiary form. The Power of Attorney paperwork is subject to review by MetLife.

I hereby revoke any previous designations, and I designate the person, people, or entity named in Section II as Beneficiary(ies). I reserve the right to change or revoke this designation at any time.

Insured/Owner Name (Please Print)

Insured/Owner Signature

Date (must be date form was completed)



How to Submit This Form

The employee should provide the completed form to their employer or benefits administrator. Retain a copy for your records.

Please note: You MUST return all pages of this form.

Last Name

First Name

M.I.

Social Security Number

Number

B

Beneficiary Designation (Attach an additional sheet to name additional beneficiaries.)**Contingent Beneficiary Designation** (Contingent beneficiary designations must total 100% - percentage can be made out to two decimal places.)

%

/ /

% of Account Balance	Contingent Beneficiary Name (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
----------------------	---------------------------------------------------------------------------	---------------------------------------------------	-----------------------------

Street Address (_____)	City	State	Zip Code
Phone Number (Optional)	Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner		

%

/ /

% of Account Balance	Contingent Beneficiary Name (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
----------------------	---------------------------------------------------------------------------	---------------------------------------------------	-----------------------------

Street Address (_____)	City	State	Zip Code
Phone Number (Optional)	Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner		

%

/ /

% of Account Balance	Contingent Beneficiary Name (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date
----------------------	---------------------------------------------------------------------------	---------------------------------------------------	-----------------------------

Street Address (_____)	City	State	Zip Code
Phone Number (Optional)	Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner		

C

Signatures and Consent (Signatures must be on the lines provided.)**Participant Consent for Beneficiary Designation** (Please sign on the 'Participant Signature' line below.)

I have completed, understand and agree to all pages of this Beneficiary Designation form. Subject to the terms of the Plan, I am making the above beneficiary designations for my vested account in the event of my death. I acknowledge and agree that it is my responsibility to monitor the beneficiary designations in my account and to update the beneficiary designations as I deem necessary upon a change in marital status, death of a beneficiary or any other change that may impact my beneficiary designations.

If I have more than one primary beneficiary, the account will be divided as specified. If a primary beneficiary predeceases me, his or her benefit will be allocated to the surviving primary beneficiaries. Contingent beneficiaries will receive a benefit only if there is no surviving primary beneficiary, as specified. If a contingent beneficiary predeceases me, his or her benefit will be allocated to the surviving contingent beneficiaries. If I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan or applicable law. This designation is effective upon execution and delivery to Plan Administrator. If any information is missing, additional information may be required prior to recording my designation.

This designation supersedes all prior designations. Beneficiaries will share equally if percentages are not provided and any amounts unpaid upon death will be divided equally. **Primary and contingent beneficiaries must separately total 100%. The percentages can be divided up to two decimal points (Example: 33.33%).**

Important Notice: In accordance with ERISA and/or Plan Document, if I am married and I elect a primary beneficiary other than my spouse or in addition to my spouse, my spouse must consent by signing the Spousal Consent for Beneficiary Designation section of this form.

Any person who presents a false or fraudulent claim is subject to criminal and civil penalties.

Participant Signature _____ **Date (Required)** _____

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Last Name

First Name

M.I.

Social Security Number

Number

C Signatures and Consent <i>(Signatures must be on the lines provided.)</i>				
Spousal Consent for Beneficiary Designation <i>(If applicable, please have the Spouse sign on the 'Spouse's Signature' line below.)</i>				
<p>Spouse to complete: I, <i>(name of spouse)</i> _____, the current spouse of the participant, hereby voluntarily consent to the participant's primary beneficiary designation above and understand its effect. I understand that my spouse's beneficiary designation means that I will not receive 100% of his or her vested account balance under the Plan and that my spouse's election is not valid unless I consent to it. I understand that my consent is irrevocable unless my spouse changes the beneficiary designation, or designates me to receive 100% of his or her vested account balance.</p>				
Spouse's Signature _____			Date (Required) _____	
<i>A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.</i>				
<p><i>The spouse's signature must be notarized by a Notary Public. The date of the spouse's signature on this form on the Spouse's signature line above must match the date of the Notary Public signature on the separate jurat or notarial certificate or in this section below. Consent must be obtained no more than 180 days prior to the effective date of the original request in order to be effective. If your notary completes a separate jurat or notarial certificate, your spouse must still sign on the above spouse's signature line and enter the date on this form.</i></p>				
<p>ATTENTION Notary Public: Make sure that you have reviewed the notary requirements for your state. If your state requires a separate jurat or notarial certificate, please complete and attach to this request.</p>				
<p>We require that the following information must be included on the separate jurat or notarial certificate: (1) name of document being notarized; (2) the plan name; (3) the plan number; and (4) participant's and spouse's names. Separate jurat or notarial certificates submitted that do not include this information will be rejected and will delay the withdrawal request. If your state does require a separate jurat or notarial certificate and you complete the section below, this statement of notary will be rejected and will delay the withdrawal request.</p>				
<p>If your state does not require a separate jurat or notarial certificate, you may complete the notary section below.</p>				
Statement of Notary		NOTE: Notary seal must be visible. The consent to this request was subscribed and sworn <i>(or affirmed)</i>		
State of _____		to before me on this _____ day of _____, year _____, by _____		
)ss. <i>(name of spouse)</i> _____		SEAL		
County/Parish/Borough _____ of _____ proved to me on the basis of satisfactory evidence to be the person who appeared before me, who affirmed that such consent represents his/her free and voluntary act.				
Notary Public's signature _____ My commission expires ____ / ____ / ____ <i>A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.</i>				
Notary Public's full name _____ Telephone number _____				
Authorized Plan Administrator Signature <i>(Please sign on the 'Authorized Plan Administrator Signature' line below.)</i>				
<p>I accept the information provided by the participant on this form.</p>				
Authorized Plan Administrator Signature _____ Date (Required) _____				
<i>A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.</i>				
Print Full Name _____				
D Delivery Instructions				
Participant forward this form to Plan Administrator. Plan Administrator DO NOT send this form to Service Provider. Please retain for your records.				

The group variable annuity insurance products are issued through Empower Annuity Insurance Company, Hartford, CT and distributed through Empower Financial Services, Inc., (EFSI). Both are Empower companies and each organization is solely responsible for its financial condition and contractual obligations. Annuity contracts contain exclusions, limitations, reductions of benefits and terms for keeping them in force. The annuity or certain of its investment options or features may not be available in all states. Policy forms currently available include DC-08-TGWB-2011, ALC-408-TGWB-2011-NR, ALC-408-TGWB-2011-ROTH, IND-IFX-TGWB-2013-NR, IND-IFX-TGWB-2013-ROTH or state variation thereof.

You could lose money by investing in money market investments. Although they seek to preserve the value of your investment at \$1 or \$10.00 per share (see the prospectus), there is no guarantee they will. An investment in a money market investment is not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency. The money market investment's sponsor has no legal obligation to provide financial support to the portfolio, and you should not expect that the sponsor will provide financial support to the portfolio at any time. The yield quotation more closely reflects the current earnings of the portfolio than the total return quotation.

This page is for informational purposes only - Do not return with the Beneficiary Designation form
EXAMPLE BENEFICIARY DESIGNATIONS

Example 1: Multiple Individuals as Beneficiaries

B	Beneficiary Designation (Attach an additional sheet to name additional beneficiaries.)			
Primary Beneficiary Designation (Primary beneficiary designations must total 100% - percentage can be made out to two decimal places.)				
<ul style="list-style-type: none"> • If I am married, my Plan requires my spouse to be named as primary beneficiary for 100% of my account balance, or my spouse must consent to my beneficiary designation. • See the attached examples on how to complete the below beneficiary designations if the beneficiary is a non-individual, such as a trust, charity or estate. 				
33.33 %	John M. Doe	XXX-XX-XXXX	01/06/1954	
% of Account Balance	Primary Beneficiary (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date	
111 Elm Street	Anytown	MO	60000	
Street Address	City	State	Zip Code	
(XXX) XXX-XXXX	Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.)			
Phone Number (Optional)	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input checked="" type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner			
33.33 %	Don M. Doe	XXX-XX-XXXX	01/06/1954	
% of Account Balance	Primary Beneficiary (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date	
222 North Avenue	Anytown	CA	90000	
Street Address	City	State	Zip Code	
(XXX) XXX-XXXX	Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.)			
Phone Number (Optional)	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input checked="" type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner			
33.34 %	Michelle L. Doe	XXX-XX-XXXX	01/06/1957	
% of Account Balance	Primary Beneficiary (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date	
333 West Blvd	Anytown	CO	80000	
Street Address	City	State	Zip Code	
(XXX) XXX-XXXX	Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.)			
Phone Number (Optional)	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input checked="" type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner			

Example 2: Trust as Beneficiary

B	Beneficiary Designation (Attach an additional sheet to name additional beneficiaries.)			
Primary Beneficiary Designation (Primary beneficiary designations must total 100% - percentage can be made out to two decimal places.)				
<ul style="list-style-type: none"> • If I am married, my Plan requires my spouse to be named as primary beneficiary for 100% of my account balance, or my spouse must consent to my beneficiary designation. • See the attached examples on how to complete the below beneficiary designations if the beneficiary is a non-individual, such as a trust, charity or estate. 				
100 %	Trust of Jane Doe	XX-XXXXXXX	06/30/2015	
% of Account Balance	Primary Beneficiary (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date	
150 Main Street	Anytown	MO	60000	
Street Address	City	State	Zip Code	
(XXX) XXX-XXXX	Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.)			
Phone Number (Optional)	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input checked="" type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner			

This page is for informational purposes only - Do not return with the Beneficiary Designation form
EXAMPLE BENEFICIARY DESIGNATIONS

Example 3: Estate as Beneficiary

B	Beneficiary Designation (Attach an additional sheet to name additional beneficiaries.)			
Primary Beneficiary Designation (Primary beneficiary designations must total 100% - percentage can be made out to two decimal places.)				
<ul style="list-style-type: none"> • If I am married, my Plan requires my spouse to be named as primary beneficiary for 100% of my account balance, or my spouse must consent to my beneficiary designation. • See the attached examples on how to complete the below beneficiary designations if the beneficiary is a non-individual, such as a trust, charity or estate. 				
100 %	Estate of Anne Doe			/ /
% of Account Balance	Primary Beneficiary (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date	
45 East Road Street Address	Anytown City	MO State	60000 Zip Code	
(XXX) XXX-XXXX Phone Number (Optional)		Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input checked="" type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input type="checkbox"/> Other <input type="checkbox"/> Domestic Partner		

Example 4: Charity as Beneficiary

B	Beneficiary Designation (Attach an additional sheet to name additional beneficiaries.)			
Primary Beneficiary Designation (Primary beneficiary designations must total 100% - percentage can be made out to two decimal places.)				
<ul style="list-style-type: none"> • If I am married, my Plan requires my spouse to be named as primary beneficiary for 100% of my account balance, or my spouse must consent to my beneficiary designation. • See the attached examples on how to complete the below beneficiary designations if the beneficiary is a non-individual, such as a trust, charity or estate. 				
100 %	ABC Charity			XX-XXXXXXX / /
% of Account Balance	Primary Beneficiary (Name of Individual, Trust, Charity, etc.)	Social Security or Taxpayer Identification Number	Date of Birth or Trust Date	
75 South Place Street Address	Anytown City	CO State	80000 Zip Code	
(XXX) XXX-XXXX Phone Number (Optional)		Relationship (Required - If Relationship is not provided, request will be rejected and sent back for clarification.) <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Grandchild <input type="checkbox"/> Sibling <input type="checkbox"/> My Estate <input type="checkbox"/> A Trust <input checked="" type="checkbox"/> Other <input type="checkbox"/> Domestic Partner		

UA LOCAL 190 PENSION PLAN

Beneficiary Designation Form

Section 1 – Primary Beneficiary

Primary Beneficiary: If you die before your entire vested accrued benefit has been paid to you, who should receive any death benefit payable under the Plan? Please check one of the boxes below, and fill in the name(s) of your beneficiary(ies) and the shares to be received.

I am Unmarried and I designate the beneficiary(ies) named below to receive benefits under the Plan after my death in the shares indicated. (Spouse consent does not apply.)

I am Married and I designate my spouse to receive all benefits under the Plan after my death. (No spouse consent required.)

I am Married and I designate the beneficiary(ies) named below to receive all death benefits under the Plan in shares indicated. (**Spouse consent is required below.**)

Name of Beneficiary	Share	Name of Beneficiary	Share
_____	_____ %	_____	_____ %
_____	_____ %	_____	_____ %

Section 2 – Contingent Beneficiary

If the person(s) chosen above are not alive at your death, who should receive any death benefit payable under the Plan? Please fill in the name and share of death benefits to be received by each such person.

Name of Beneficiary	Share	Name of Beneficiary	Share
_____	_____ %	_____	_____ %
_____	_____ %	_____	_____ %

Section 3 – Participant Signature

I hereby sign this Beneficiary Designation. If I am married and have designated a Primary Beneficiary other than my spouse, I hereby waive the Qualified Pre-retirement Survivor Annuity.

Print Name: _____ Signature: _____ Date: _____ Last 4 of SS: _____

Section 4 - Spouse's Consent to Beneficiary Designation

I consent to my spouse's designation of primary beneficiaries named in Section 1 above to receive death benefits. I have read the Notice of Qualified Pre-retirement Survivor Annuity. I Understand (1) that pension laws require that I receive a Qualified Pre-retirement Survivor Annuity if my spouse predeceases me; (2) however, by signing this consent, I will lose my right to receive a Qualified Pre-retirement Survivor Annuity; (3) that I will receive a death benefit only if I am named a Primary Beneficiary in Section 1; (4) that my spouse's designation is not valid unless I consent to it; and (5) that I cannot change my consent after I sign this form.

This consent is subject to the following condition: (**Choose one**)

No Change in my spouse's Beneficiary Designation shall be made without my consent

My spouse may change the Beneficiary Designation at any time without further consent by me. I understand that I have the right to limit my consent to a specific beneficiary and I voluntarily elect to permanently waive that right.

Date: _____ Signature: _____ -

STATE OF MICHIGAN)
) ss
COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____, by _____

, Notary Public

County, Michigan

My Commission Expires: _____

See Reverse for Instructions

Instructions

1. Please complete the attached Beneficiary Designation on page 1 of this form and return it to the Plan Administrator as soon as possible. If no Beneficiary Designation is filed or if the last filed designation is revoked, your Plan death benefit will be paid to your spouse, if any; if no spouse is alive, to your children, if any; and if no spouse or children are alive, to your estate.
2. You have the right to revoke or amend the Beneficiary Designation before benefit payment begins, and the last Beneficiary Designation filed before payment begins will be irrevocable.
3. Please fill out the Beneficiary Designation as follows:
 - a. Check one box under "Primary Beneficiary(ies)" (Section 1)
 - b. Fill in the name(s) of all primary beneficiaries and the shares they are to receive of any death benefit that becomes payable. If you do not specify otherwise, the beneficiaries will receive equal shares. Be sure to fill in the name of your spouse if he or she is to receive any part of the death benefit. Include the address and social security number of each person designated. Attach extra pieces of paper if needed. If a primary beneficiary dies before the entire amount is distributed, the remaining amount will be reallocated among surviving primary beneficiaries.
 - c. Fill in the names of any contingent beneficiaries. If all primary beneficiaries die before all benefits are distributed, remaining benefits will be reallocated among contingent beneficiaries designated by you. If no contingent beneficiaries are designated remaining benefits will be distributed as described above. (Section 3)
 - d. Sign and date the form. (Section 3)
4. Be sure to inform the Plan Administrator if your marital status changes, because that could affect the validity of your Beneficiary Designation

Notice of Qualified Pre-Retirement Survivor Annuity

If you die before benefit payments begin and you are married at the time of your death, pension laws require a **"spousal death benefit"** be paid to your spouse. Your spouse will receive a lifetime annuity with monthly payments equal to 100% of the payments you would have received if you had retired on the day before your death. This benefit is called a **Qualified Pre-retirement Survivor Annuity**.

You may name a different beneficiary to receive the spousal death benefit. If you elect a different beneficiary, you will be considered to have "waived" the Qualified Pre-retirement Survivor Annuity. However, your election will be effective only if your spouse consents to the different beneficiary in writing in the "Spouse's Consent to Beneficiary Designation" on page 1 of this form. **Consent must be notarized**. By checking one of the boxes above the spouse signature, your spouse may limit the consent to the specific persons named by you on the Beneficiary Designation or may let you make future changes without further consent.

You can revoke such an election at any time. If the election is revoked, then the spousal death benefit will once again be paid to your spouse as a Qualified Pre-retirement Survivor Annuity. If you do not revoke your election, it will be effective for different periods of time depending on your age at the time the election is made. If your election is made before the Plan Year in which you turn age 35, it will remain until the first day of the Plan Year in which you reach age 35. If your election is made after the Plan Year in which you reach age 34, it will remain in effect until you change it. You are responsible for notifying the Plan and requesting new forms if you initially waive the annuity or name a beneficiary other than your spouse before the Plan Year in which you reach age 35.

If you want your spouse to receive the spousal death benefit, you need not be concerned with the age 35 election requirements or the spouse consent requirements.



UA Local 190
P.O. Box 328
Troy, MI 48099
Toll Free: (888) 390-7473
Website: www.UA190Benefits.org

Enhanced Member Benefit Website

www.UA190Benefits.org

Dear Member:

The Trustees of the UA Local 190 Fringe Benefit Funds are pleased to announce a new enhanced member benefit website, www.UA190Benefits.org. This website has been fully updated to provide you with a more effective way to access and manage your benefits.

The website enables you to obtain basic benefit information about the Plan, review answers to frequently asked questions, access your personal benefit information, and communicate with the Benefit Office via e-mail. You can also find helpful links regarding benefits provided by the Plan.

To access your personal benefit information, such as your benefit elections, work history detail, forms, and Plan documents, you need to register as a new user by clicking the *Create an Account* link at the top right hand corner in the Login box. More detailed instructions are shown on the back of this letter. Once you are registered, you can access your personal benefit information by entering your **Username** and **Password**, so please keep these confidential. **Please note, only one username and password is permitted per email address. If more than one person in your family requires website access, each must use a different email address.**

Every member, spouse, and dependent over the age of 18 will need to create their own login that will give them access to their own Protected Health Information (PHI). Each person that creates their own username and password will not have their PHI available for viewing by any other user.

Please contact the Benefit Office at (888) 390-7473 if you encounter any difficulty logging in, or if you have any questions regarding the Member Benefit website. You can also email the Benefit Office directly by using the “Contact Us” section of the website.

Please visit the enhanced Member Benefit website soon and see all that it has to offer!

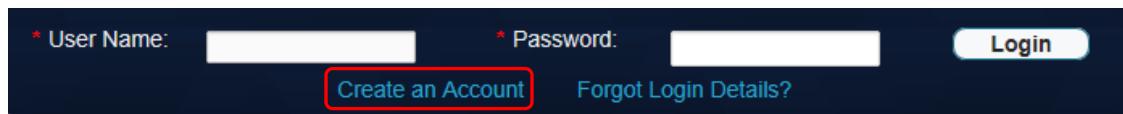
Board of Trustees,

UA Local 190

HOW TO REGISTER ON THE WEBSITE

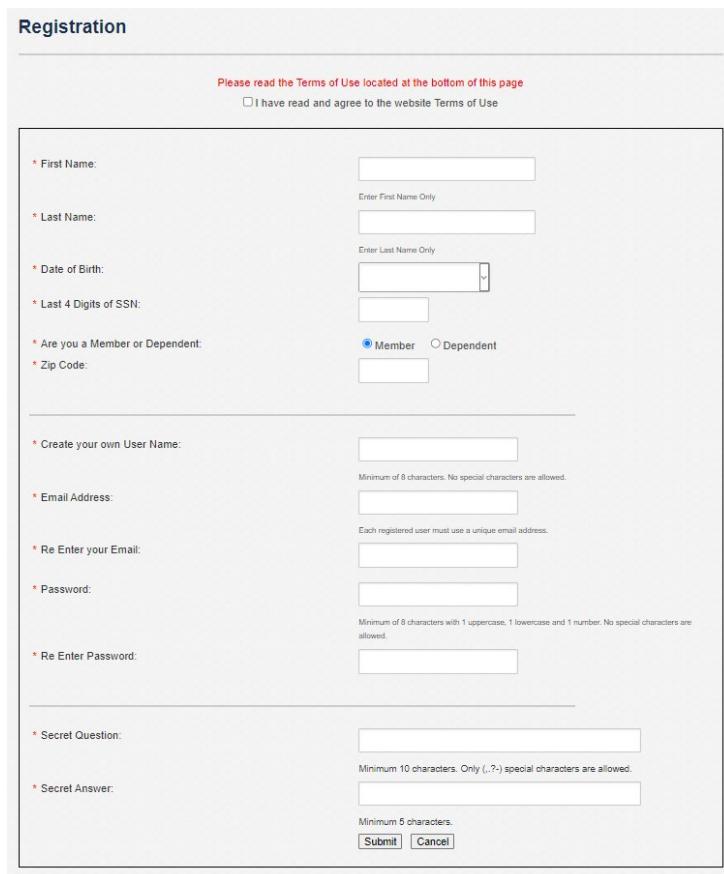
When registering for the first time, please follow these instructions:

- 1) From your computer or mobile device, connect to the website listed on the front page of this letter.
- 2) Locate the Login box in the upper right-hand corner of the screen.
- 3) Click on “Create an Account” to get started.



The image shows a dark-themed login interface. At the top, there are fields for "User Name" and "Password", and a "Login" button. Below these are two links: "Create an Account" and "Forgot Login Details?". The "Create an Account" link is highlighted with a red box.

- 4) The Registration Screen will display next. Please enter all information, as all fields are required. Once all information has been entered, please click “Submit” on the bottom of the screen.



The registration form is titled "Registration". It includes a note to read the Terms of Use and a checkbox for agreeing to them. The form contains the following fields:

- * First Name: Text input field with placeholder "Enter First Name Only".
- * Last Name: Text input field with placeholder "Enter Last Name Only".
- * Date of Birth: Text input field with a dropdown arrow.
- * Last 4 Digits of SSN: Text input field.
- * Are you a Member or Dependent: Radio buttons for "Member" (selected) and "Dependent".
- * Zip Code: Text input field.
- * Create your own User Name: Text input field with placeholder "Minimum of 8 characters. No special characters are allowed.".
- * Email Address: Text input field with placeholder "Each registered user must use a unique email address.".
- * Re Enter your Email: Text input field.
- * Password: Text input field with placeholder "Minimum of 8 characters with 1 uppercase, 1 lowercase and 1 number. No special characters are allowed.".
- * Re Enter Password: Text input field.
- * Secret Question: Text input field with placeholder "Minimum 10 characters. Only (.,?) special characters are allowed.".
- * Secret Answer: Text input field with placeholder "Minimum 5 characters.".

At the bottom are "Submit" and "Cancel" buttons.

- 5) After registering you will receive an email notification with a link to confirm your registration. Your email address will also be used in the event you forget your user name and password.

Profile Confirmation

Your authentication has been verified. Please login with your password. Please [Click here](#) to login.