All Alaska Longshore Health & Welfare Trust

Beneficiary Designation Form

Please check the appropriate box for the plan(s) that apply to this beneficiary designation form:

- ☐ IBU of the Pacific National Health Benefit Trust
- ☐ All Alaska Longshore Health Benefit Trust
- ☐ All Alaska Longshore Pension Plan

Member's Name: _____ **Social Security Number:** _____

DESIGNATED BENEFICIARY NAME: (Primary Beneficiary)		Date of Birth:		SSN	
Relationship		Percentage of Benefit to be Received			
Phone		Address:			

BENEFICIARY NAME:		Date of Birth:		SSN	
Relationship		Percentage of Benefit to be Received			
Phone		Address:			

BENEFICIARY NAME:		Date of Birth:		SSN	
Relationship		Percentage of Benefit to be Received			
Phone		Address:			

CONTINGENT BENEFICIARY NAME (Secondary Beneficiary)		Date of Birth:		SSN	
Relationship		Percentage of Benefit to be Received			
Phone		Address:			

Custodial Designation

If my above named beneficiary is a minor, I hereby designate (print full name)_____ to act as Custodian to receive such benefits on behalf of such child (or children). I understand that I may change this Custodial Designation at any time. I also understand that if I fail to name a Custodian, then the natural parent(s) of the minor will automatically be designated as Custodian. I also understand that if the amount of the benefit is more than $10,000, and I fail to name a Custodian, the benefit cannot be paid until a Custodian is appointed by the Superior Court.

CUSTODIAN NAME:		Date of Birth:		SSN	
Relationship		Address:			
Phone					

*If you designate more than one Beneficiary, benefits will be paid to them in equal shares, unless you fill in a different percentage to be received where indicated on this form. For example, if you name two beneficiaries you may state that one will receive 75% and the other 25%. Benefits will be paid to the person you list as a Secondary Beneficiary only in the event your designated Beneficiaries have died. If you fail to designate a Beneficiary or if all of your designated Beneficiaries have died, the benefits will be paid in

Member's Signature: _____ **Date:** _____

Witness (Non-Relative) Signature: _____ **Date:** _____

Witness Address: _____

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