BENEFICIARY DESIGNATION

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

IBU of the Pacific National Health Benefit Trust ☐

IBU of the Pacific National Pension Plan ☐
1220 SW Morrison St, Suite 300, Portland, Oregon 97205

(If you wish to designate a different beneficiary or beneficiaries for each Plan, please complete a separate form.)

Participant Name:_____ Phone_____

Address:_____
Street City State Zip

Social Security Number:_____ Date of Birth:_____

Designated Beneficiary (Primary Beneficiary): Any ONE-TIME CASH PAYMENT from the Trust(s) because of my death shall be paid to the following person(s):

Name:_____ Designated %

Address:_____
Street City State Zip ☐

Relationship:_____

Date of Birth:_____ SS#:_____

Name:_____ Designated %

Address:_____
Street City State Zip ☐

Relationship:_____

Date of Birth:_____ SS#:_____

Name:_____ Designated %

Address:_____
Street City State Zip ☐

Relationship:_____

Date of Birth:_____ SS#:_____

Attach additional sheet if necessary.

THE TOTAL AMOUNT ALLOCATED TO ALL BENEFICIARIES MUST EQUAL EXACTLY 100% TOTAL %

_____

If I have named more than one DESIGNATED BENEFICIARY and he/she dies before me, I understand that his/her share will be divided equally among the remaining Designated Beneficiaries.

CONTINGENT BENEFICIARY (Secondary Beneficiary):

If the DESIGNATED BENEFICIARIES die before me, the ONE-TIME CASH PAYMENT shall be made to the following person(s):

Name:_____ Designated %

Address:_____
Street City State Zip ☐

Relationship:_____

Date of Birth:_____ SS#:_____

Name:_____ Designated %

Address:_____
Street City State Zip ☐

Relationship:_____

Date of Birth:_____ SS#:_____

Name:_____ Designated %

Address:_____
Street City State Zip ☐

Relationship:_____

Date of Birth:_____ SS#:_____

Attach additional sheet if necessary.

THE TOTAL AMOUNT ALLOCATED TO ALL BENEFICIARIES MUST EQUAL EXACTLY 100% TOTAL %

_____

If I have named more than one CONTINGENT BENEFICIARY and he/she dies before me, I understand that his/her share will be divided equally among the remaining Contingent Beneficiaries.

MEMBER SIGNATURE:

_____

Date:_____

WITNESS:

_____
(Non-Relative)

ADDRESS:

_____

_____

Questions: Call (503) 224-0048 or Toll Free 1-800-547-4457 Ext 1922
Please submit the original to the Trust Office and keep a photocopy for your records.