

I.U.P.A.T. DISTRICT COUNCIL NO. 51 HEALTH AND WELFARE FUND

IMPORTANT INFORMATION ABOUT BENEFICIARY DESIGNATIONS

The ***Beneficiary Designation Form*** allows you to designate one or more beneficiaries to receive applicable benefits in the event of your death. If we do not have a designated beneficiary on file in the Fund Office, or if you do not name a beneficiary, payment may not be made to the person(s) you intend to receive the benefit. For further information regarding payment of death benefits, please refer to your Summary Plan Description. **No change in beneficiary designation shall be effective or binding on the Plan or the Trustees unless it is received by the Fund Office prior to the time any payments are made to the beneficiary (ies) whose designation is on file.**

It is also important that you keep the Plan informed of your current address. Address changes must be submitted in writing to the Fund Office.

DEFINITIONS

You may find the following definitions helpful in completing this form:

Primary Beneficiary (ies)- the person(s) or entity you designate as the first in line to receive your benefit. You may name more than one Primary Beneficiary. Payment will be made in equal shares unless otherwise specified. The percentages you list for all beneficiaries should total 100%. In the event that a designated primary beneficiary predeceases you, the benefit will be paid to remaining primary beneficiaries in equal share or all to the sole remaining primary beneficiary.

Contingent Beneficiary (ies)- the person(s) or entity you designate to receive your benefit in the event your primary beneficiary predeceases you. You may name more than one Contingent Beneficiary. Payment will be made in equal shares unless otherwise specified. The percentages you list for all beneficiaries should total 100%. In the event that a designated contingent beneficiary predeceases you, the benefit will be paid to remaining contingent beneficiaries in equal share or all to the sole remaining contingent beneficiary.

Health/Welfare- a package of hospitalization, medical, and other benefits.

INSTRUCTIONS

- Complete this form to designate one or more beneficiaries to receive applicable benefits in the event of your death for the Fund indicated.
- If you need additional space, please attach a separate sheet of paper.
- The Participant must read, sign and date the authorization.
- Submit the completed form to the Fund office and keep a copy for your records.

BENEFICIARY DESIGNATION FORM

I.U.P.A.T. DISTRICT COUNCIL NO. 51 HEALTH AND WELFARE FUND

Participant's Name		Social Security Number	
Telephone Number	Birth Date (MM/DD/YYYY) / /		Home Local
Address	City	State	Zip Code
MARITAL STATUS	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced (Provide copy of divorce decree(s).)	
	<input type="checkbox"/> Single	<input type="checkbox"/> Widowed (Provide copy of death certificate.)	
	<input type="checkbox"/> Separated		

Primary Beneficiaries:

(1) Name		Social Security Number	
Address			
Street	City	State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY) / /	Beneficiary %
(2) Name		Social Security Number	
Address			
Street	City	State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY) / /	Beneficiary %

Contingent Beneficiaries:

(1) Name		Social Security Number	
Address			
Street	City	State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY) / /	Beneficiary %
(2) Name		Social Security Number	
Address			
Street	City	State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY) / /	Beneficiary %

PARTICIPANT SIGNATURE: I certify that all information furnished in this form is true to the best of my knowledge. I understand and agree that any misrepresentation by me may constitute grounds for the denial of benefits to me or on my behalf or for the cancellation or recovery of benefit payments made in reliance thereon.

Signature of Participant

Date