

Plumbers & Pipefitters National Pension Fund - Beneficiary Designation

Instructions: Print using **ONLY** capital letters and using an ink pen. Read and follow Instructions for Completing the Beneficiary Designation Form to ensure that your form is completed properly.

Participant Information :

Social Security Number - -
 First Name Middle Name Last Name
 Jr., Sr., I, etc. Birth Date / / Phone # () -
 Address Line 1 (Street Address)
 Address Line 2 (Apt, Etc.)
 City State Zip / Canadian Postal Code
 Sex Male Female
 Local Union#

PRIMARY BENEFICIARY: I hereby designate the following person(s) as my Primary Beneficiary(ies) to receive benefits, if any, payable at my death. Fill in ALL areas below for each Beneficiary.

First Name Middle Name Last Name
 Jr., Sr., I, etc. Birth Date / / Sex Male Female
 Social Security Number - - Relationship: Select one. If 'Other', define the relationship on the line provided.
 Social Insurance Number Spouse Child Other _____
 Is the Beneficiary's address the same as the Participant's address? Yes No If 'No', complete the address section below.
 Address _____
 City _____ State _____ Zip/Canadian Postal Code _____

First Name Middle Name Last Name
 Jr., Sr., I, etc. Birth Date / / Sex Male Female
 Social Security Number - - Relationship: Select one. If 'Other', define the relationship on the line provided.
 Social Insurance Number Spouse Child Other _____
 Is the Beneficiary's address the same as the Participant's address? Yes No If 'No', complete the address section below.
 Address _____
 City _____ State _____ Zip/Canadian Postal Code _____

First Name Middle Name Last Name
 Jr., Sr., I, etc. Birth Date / / Sex Male Female
 Social Security Number - - Relationship: Select one. If 'Other', define the relationship on the line provided.
 Social Insurance Number Spouse Child Other _____
 Is the Beneficiary's address the same as the Participant's address? Yes No If 'No', complete the address section below.
 Address _____
 City _____ State _____ Zip/Canadian Postal Code _____

Designate Contingent and Successor Beneficiary(ies) on page 2.

NOTE: Signature required on page 2.

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1217646423

Bar Code No.

CONTINGENT and SUCCESSOR BENEFICIARY: If ALL Primary Beneficiary(ies) do not survive, I designate the following person(s) to be my Contingent Beneficiary(ies) to receive benefits, if any, that become due as a result of my death or that remain payable after the death of all the previously named Primary Beneficiary(ies).

First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Jr., Sr., I, etc. <input type="text"/>	Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Sex <input type="radio"/> Male <input type="radio"/> Female
Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/>	Relationship: Select one. If 'Other', define the relationship on the line provided.	
Social Insurance Number <input type="text"/>	<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other <input type="text"/>	
Is the Beneficiary's address the same as the Participant's address? <input type="radio"/> Yes <input type="radio"/> No If 'No', complete the address section below.		
Address <input type="text"/>		
City <input type="text"/>	State <input type="text"/>	Zip/Canadian Postal Code <input type="text"/>

First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Jr., Sr., I, etc. <input type="text"/>	Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Sex <input type="radio"/> Male <input type="radio"/> Female
Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/>	Relationship: Select one. If 'Other', define the relationship on the line provided.	
Social Insurance Number <input type="text"/>	<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other <input type="text"/>	
Is the Beneficiary's address the same as the Participant's address? <input type="radio"/> Yes <input type="radio"/> No If 'No', complete the address section below.		
Address <input type="text"/>		
City <input type="text"/>	State <input type="text"/>	Zip/Canadian Postal Code <input type="text"/>

First Name	Middle Name	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Jr., Sr., I, etc. <input type="text"/>	Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Sex <input type="radio"/> Male <input type="radio"/> Female
Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/>	Relationship: Select one. If 'Other', define the relationship on the line provided.	
Social Insurance Number <input type="text"/>	<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other <input type="text"/>	
Is the Beneficiary's address the same as the Participant's address? <input type="radio"/> Yes <input type="radio"/> No If 'No', complete the address section below.		
Address <input type="text"/>		
City <input type="text"/>	State <input type="text"/>	Zip/Canadian Postal Code <input type="text"/>

I understand that I may change this Beneficiary Designation at any time by filing a new Beneficiary Designation Form with the Fund Office. However, I also understand that, in accordance with the Retirement Equity Act of 1984, if I am married when I retire, my spouse must give written consent to my designation of beneficiaries.

Note: If you are already retired and Spousal Consent is needed in order to accept your form, the Fund Office will provide you with the additional forms as needed in order to complete your designation.

Signature / /
Date:

You must **sign and date** the form in order for your designation to be accepted by the Fund Office.

Plumbers & Pipefitters National Pension Fund Mailing Address:

Plumbers & Pipefitters National Pension
103 Oronoco Street
Alexandria, VA 22314-2047

Questions – 1-800-638-7442

Plumbers and Steamfitters Local Union No. 248

Health and Welfare and Pension Trust Funds

333 W. Vine Street • Suite 500

Lexington, Kentucky 40507

Tel. 859-226-1700 • Fax 859-226-1726



MEMORANDUM

TO: Member

FROM: Administrative Services Group, Inc.

RE: Plumbers and Steamfitters Local Union No. 248 Pension Trust Fund

Enclosed is a Beneficiary Designation form for the above pension plan.

Under the Plan, the Spouse or Beneficiary of a deceased Participant, upon proper proof of death to the Trustees, shall be eligible to receive a Pre-Retirement Death Benefit provided the deceased Participant had at least five (5) years of Continuous Service and died before he or she received any Normal or Early Retirement Benefit payments.

Pre-retirement death benefits will be made in either of two methods as follows:

- A. Lump Sum Payment of Percentage of Employer Contributions; or
- B. Survivor Benefit.

You may designate a beneficiary other than your spouse only with your spouse's consent. If you die without designating a beneficiary, the death benefit will be paid as follows:

- (a) to your legal spouse or, if none,
- (b) to your dependent children or, if none,
- (c) to your estate.

Please complete the Beneficiary Designation form and return it to Administrative Services Group, Inc. You may change your beneficiary designation at any time by completing a new Beneficiary Designation form. However, benefits will be paid based on the latest designation in our file. If you have any questions, please call 888-640-1700 (toll free).

PLUMBERS AND STEAMFITTERS LOCAL UNION NO. 248 PENSION TRUST FUND
333 West Vine Street, Suite 500, Lexington KY 40507 – (859) 226-1700 / 888-999-7741

BENEFICIARY DESIGNATION

EMPLOYEE NAME: _____

EMPLOYEE SOC. SEC. NO.: _____

BENEFICIARY NAME(S):

Name of Beneficiary (Primary)	Social Security No.	Relationship to Employee	Date of Birth

Name of Beneficiary (Secondary)	Social Security No.	Relationship to Employee	Date of Birth

THE PRIMARY BENEFICIARY DESIGNATED WILL RECEIVE BENEFITS ON YOUR BEHALF UPON YOUR DEATH. HOWEVER, YOU MAY ALSO DESIGNATE SECONDARY BENEFICIARY(IES) TO RECEIVE BENEFITS IN THE EVENT THE PRIMARY BENEFICIARY'S DEATH IS PRIOR TO THE COMMENCEMENT OF BENEFITS.

Note: If your spouse is not designated as your primary beneficiary, they must consent to your beneficiary designation (see back of form).

IF TWO OR MORE BENEFICIARIES ARE NAMED, THE PROCEEDS SHALL BE PAID TO THE NAMED BENEFICIARIES IN EQUAL SHARES.

A PARTICIPANT MAY CHANGE THEIR BENEFICIARY DESIGNATION AS NEEDED; HOWEVER, NO CHANGE WILL BE EFFECTIVE UNTIL THE NEW DESIGNATION HAS BEEN RECEIVED BY THIS OFFICE.

THIS BENEFICIARY DESIGNATION SUPERSEDES ANY AND ALL PRIOR BENEFICIARY DESIGNATIONS SUBMITTED BY ME.

DATE

SIGNATURE OF PARTICIPANT

Continued on back of form.

PLUMBERS AND STEAMFITTERS LOCAL UNION NO. 248 PENSION TRUST FUND

SPOUSAL CONSENT

I hereby certify that I, _____ am the spouse of the above-named Participant, and I have read this form as completed and signed by the Participant. I understand that, upon the Participant's death, I am entitled to any unpaid Plan benefits unless I consent to the Participant's designation of a non-spouse beneficiary. In granting this consent, I understand that I am waiving any right I might have to any benefit under the plan if the Participant dies, except to the extent that he or she may name me specifically as a Beneficiary herein. The designated beneficiar(ies) may not be changed at any time during which I am married to the Participant (except to designate me as his or her sole primary beneficiary) without my written consent on a form similar to this one. I hereby acknowledge and consent to the Participant's designation of the beneficiary(ies) listed above.

DATE

SIGNATURE OF SPOUSE

TO BE COMPLETED BY NOTARY PUBLIC:

STATE OF _____

COUNTY OF _____

BEFORE ME, the undersigned, a Notary Public, personally appeared _____
Who executed the above SPOUSAL WAIVER as a free and voluntary act.

IN WITNESS WHEREOF, I have signed my name and affixed my notarial seal this _____
day of _____ 20 ____.

NOTARY PUBLIC

My Commission Expires _____

PLUMBERS & STEAMFITTERS LOCAL 248 HEALTH & WELFARE FUND
GROUP ENROLLMENT CARD

(Please Print or Type)

Name of Employee: _____ (Last) _____ (First) _____ (Middle Initial)

Address: _____

Check One: Male: _____ Female: _____ Married: _____ Single: _____

S. S. #: _____ Date of Birth: _____

Work Telephone _____ Home Telephone _____

Primary Beneficiary / Relationship _____

Address _____

Contingent Beneficiary / Relationship _____

Address _____

I apply for Group Insurance for which I am or may become eligible.

Signature of Employee: _____ Date Signed: _____