



**Plumbers & Pipefitters National Pension Fund - Beneficiary Designation**

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

Jr., Sr., I, etc.  Birth Date  /  /  Sex  Male  Female

Social Security Number  -  -  Relationship: Select one. If 'Other', define the relationship on the line provided.  
 Spouse  Child  Other

Social Insurance Number

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.  
 Spouse  Child  Other

Social Insurance Number

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.  
 Spouse  Child  Other

Social Insurance Number

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

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***  
***Pension Fund***

333 West Vine Street • Suite 500 • Lexington, Kentucky 40507  
Toll-Free 888-999-7741 • Fax 859-226-1191

**MEMORANDUM**

TO: Member

FROM: UMR, Fund Administrator

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

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Enclosed is a Beneficiary Designation form for the above-referenced 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 888-999-7741 (toll free).

PLUMBERS AND STEAMFITTERS LOCAL NO. 248 PENSION TRUST FUND  
333 WEST VINE STREET ▪ SUITE 500 ▪ LEXINGTON, KY 40507  
PH: (888) 999-7741 FAX (859) 226-1191

BENEFICIARY DESIGNATION

EMPLOYEE NAME: \_\_\_\_\_

EMPLOYEE SOC. SEC. NO.: \_\_\_\_\_

BENEFICIARY NAME(S):

Name of Beneficiary <b>(Primary)</b>	Social Security No.	Relationship to Employee	Date of Birth

Name of Beneficiary <b>(Secondary)</b>	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.

\_\_\_\_\_  
SIGNATURE OF PARTICIPANT

\_\_\_\_\_  
DATE

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.

\_\_\_\_\_  
SIGNATURE OF SPOUSE

\_\_\_\_\_  
DATE

**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 and Steamfitters Local Union No. 248

### Annuity Fund

333 West Vine Street • Suite 500 • Lexington, Kentucky 40507  
Toll-Free 888-999-7741 • Fax 859-226-1191

### **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.

SIGNATURE OF PARTICIPANT: \_\_\_\_\_

DATE: \_\_\_\_\_

## **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 beneficiary(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.

SIGNATURE OF SPOUSE: \_\_\_\_\_

DATE: \_\_\_\_\_

### **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: \_\_\_\_\_

( S E A L )





## Plumbers and Steamfitters Local Union No. 248

### Health and Welfare Trust Fund

333 West Vine Street • Suite 500 • Lexington, Kentucky 40507  
Toll-Free 888-999-7741 • Fax 859-226-1191

#### BENEFICIARY ELECTION / CHANGE FORM

##### SECTION I - GENERAL INFORMATION

EMPLOYEE NAME:	_____	_____	_____
	Last Name	First Name	Middle Initial
ADDRESS:	_____	_____	_____
	Street	City	Zip Code
SOCIAL SECURITY NUMBER:	_____	DATE OF BIRTH:	_____
CHECK ONE:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single
TELEPHONE:	_____	_____	_____
	Work	Home	Cell

##### SECTION II - INSTRUCTIONS FOR COMPLETING LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFICIARY ELECTION / CHANGE FORM

**IMPORTANT INFORMATION ABOUT YOUR BENEFICIARY DESIGNATIONS:** Use this form to designate or make changes to the beneficiary(ies) of your Plumbers and Steamfitters Local Union No. 248 Health and Welfare Group Insurance death proceeds. The information on this form will replace any prior beneficiary designation. You may name any one or any entity as your beneficiary and you may change your beneficiary at any time by completing a new Plumbers and Steamfitters Local Union No. 248 Health and Welfare Fund Beneficiary Designation/Change form. **Payment will be made to the named beneficiary. If there is no named beneficiary or the named beneficiary predeceased you payment will be made in accordance with the terms of the Group Contract issued to the Plumbers and Steamfitters Local Union No. 248 Health and Welfare Fund.**

Please note in order to be eligible for this benefit you must be:

- an eligible Active Employee for the \$10,000 life with matching \$10,000 Accidental Death and Dismemberment benefits; or
- an eligible Retiree for the \$2,000 life-only benefit.

You will need to choose one or more Primary Beneficiaries.

- The Primary Beneficiary(ies) will receive insurance proceeds in the event of your death. If you do not indicate a "Benefit Percent" the proceeds will be divided equally among your chosen Primary Beneficiaries. If you select only one Primary Beneficiary, that Beneficiary will receive 100% of the proceeds. If you name more than one Beneficiary with unequal shares, please show the percent of insurance to be paid to each beneficiary. All percentages must total 100%.

For Example: 40% to Name of Wife 30% to Name of Daughter 30% to Name of Sister = 100%

- A Contingent Beneficiary is a beneficiary who receives the insurance proceeds in the event that all of your Primary Beneficiaries have pre-deceased you (i.e., they have died at or before the date of your death). If one or more but not all of your Primary Beneficiaries have died on or before your date of death, the surviving beneficiary(ies) will receive 100% of your insurance.
- If you make a change on this form (cross-outs, overwrites, etc.) please initial and date the changes before submitting the form.
- If you need to list additional beneficiaries, make a copy of this form and indicate at the top of the form(s) that you are choosing additional beneficiaries.

##### SECTION III - BENEFICIARY DESIGNATION(S)

I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and in the event of my death, I designate the following:

##### IMPORTANT INFORMATION:

Divorce automatically cancels a former spouse's beneficiary designation. If you want to keep your ex-spouse as a beneficiary, you must file a new form with "ex-spouse" or "friend" in the "RELATIONSHIP TO EMPLOYEE" Section of the Beneficiary Designation Section below.

**(APPLICATION CONTINUED ON BACK OF PAGE)**



CHECK ONE:

Initial Election

Beneficiary Change

NAME OF BENEFICIARY: *Note: If Co-Beneficiary, please indicate % of total benefit to be paid to each beneficiary.*

CHECK ONE:

<input type="checkbox"/> Primary	RELATIONSHIP TO EMPLOYEE: _____	% OF BENEFIT: _____	%
<input type="checkbox"/> Co-Primary	RELATIONSHIP TO EMPLOYEE: _____	% OF BENEFIT: _____	%
<input type="checkbox"/> Contingent	RELATIONSHIP TO EMPLOYEE: _____	% OF BENEFIT: _____	%
<input type="checkbox"/> Co-Contingent	RELATIONSHIP TO EMPLOYEE: _____	% OF BENEFIT: _____	%

ADDRESS: \_\_\_\_\_  
Street City Zip Code

NAME OF BENEFICIARY: *Note: If Co-Beneficiary, please indicate % of total benefit to be paid to each beneficiary.*

CHECK ONE:

<input type="checkbox"/> Primary	RELATIONSHIP TO EMPLOYEE: _____	% OF BENEFIT: _____	%
<input type="checkbox"/> Co-Primary	RELATIONSHIP TO EMPLOYEE: _____	% OF BENEFIT: _____	%
<input type="checkbox"/> Contingent	RELATIONSHIP TO EMPLOYEE: _____	% OF BENEFIT: _____	%
<input type="checkbox"/> Co-Contingent	RELATIONSHIP TO EMPLOYEE: _____	% OF BENEFIT: _____	%

ADDRESS: \_\_\_\_\_  
Street City Zip Code

NAME OF BENEFICIARY: *Note: If Co-Beneficiary, please indicate % of total benefit to be paid to each beneficiary.*

CHECK ONE:

<input type="checkbox"/> Primary	RELATIONSHIP TO EMPLOYEE: _____	% OF BENEFIT: _____	%
<input type="checkbox"/> Co-Primary	RELATIONSHIP TO EMPLOYEE: _____	% OF BENEFIT: _____	%
<input type="checkbox"/> Contingent	RELATIONSHIP TO EMPLOYEE: _____	% OF BENEFIT: _____	%
<input type="checkbox"/> Co-Contingent	RELATIONSHIP TO EMPLOYEE: _____	% OF BENEFIT: _____	%

ADDRESS: \_\_\_\_\_  
Street City Zip Code

**AUTHORIZATION/SIGNATURE:** I authorize the Plumbers and Steamfitters Local Union No. 248 Health and Welfare Fund to record and consider the individuals/institutions that I have named on this form as beneficiaries for benefits under the Plumbers and Steamfitters Local Union No. 248 Health and Welfare Fund's Group Insurance Plan. If designating a Trust as a beneficiary, I understand that the Plumbers and Steamfitters Local Union No. 248 Health and Welfare Fund has no obligations as to the validity of sufficiency of any executed Trust Agreement.

SIGNATURE OF EMPLOYEE: \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

PLEASE PRINT NAME: \_\_\_\_\_

**PLEASE RETURN THIS  
FORM TO:**

*Plumbers and Steamfitters Local Union No. 248 Health and Welfare Trust Fund*  
ATTN: Taft-Hartley Eligibility Department  
333 West Vine Street, Suite 500  
Lexington, KY 40507