

# INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL 98 BENEFIT FUNDS

40 Hudson Drive, P.O. Box 1290, Southwick, MA 01077  
Telephone: (413)998-3230 Fax: (413) 998-3249

HEALTH & WELFARE FUND  
PENSION FUND  
ANNUITY FUND  
J L M COOPERATIVE TRUST



Kara A. Richotte  
FUND ADMINISTRATOR

## Beneficiary Designation Form

Please complete this form and return to the Local 98 Fund Office as soon as possible.

Member Name \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_  
Street  
City State Zip Code

Social Security # \_\_\_\_\_ Phone \_\_\_\_\_

This designation applies to: **ALL FUNDS** \_\_\_\_\_

Health & Welfare Fund ONLY \_\_\_\_\_ Pension Fund ONLY \_\_\_\_\_ Annuity Fund ONLY \_\_\_\_\_

**NOTE: If you are a participant in more than one Fund and you do not check ALL FUNDS you must complete a separate form for each Fund in which are a participant.**

**PRIMARY BENEFICIARY(IES)** - Indicate % for each beneficiary - must equal 100%

1) Full Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Percentage \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

2) Full Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Percentage \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

3) Full Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Percentage \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

If no Primary Beneficiary survives the member, then the proceeds will be paid to:

**CONTIGENT BENEFICIARY(IES) - Indicate % for each beneficiary - must equal 100%**

1) Full Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Percentage \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

2) Full Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Percentage \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

3) Full Name \_\_\_\_\_ Social Security Number \_\_\_\_\_ Percentage \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

**It is your responsibility to keep your beneficiary information updated. Please contact the Fund Office at (413) 998-3230 if you need to make changes to your beneficiary designation. You can also find this form on our website at [www.iuoelocal98.org](http://www.iuoelocal98.org).**

I the undersigned, agree that:

- I understand that this form is subject to all of the terms and conditions set forth in the I.U.O.E. Local 98 Health & Welfare Fund, Pension Fund and Annuity Fund Plan Documents.
- I reserve the right to make further changes to my beneficiary designations and will provide spousal waiver, if applicable.
- I understand that if any or all of my accumulated benefits for which this designation applies is subject to Spousal Consent under the Plan rules or ERISA rules, and I designate someone other than my spouse as my beneficiary, my spouse must complete a spousal consent waiving his/her right to whatever portion of the benefits he/she is legally entitled to.
- I understand and agree to the changes and updates I made on this form.

Member Signature \_\_\_\_\_

Date \_\_\_\_\_

Notary Public Certification

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, before me, the undersigned notary public personally appeared \_\_\_\_\_ (name of document signer), proved to me through satisfactory evidence of identification which were \_\_\_\_\_, to be the person whose name is signed on the preceding or attached document in my presence.

(seal)

\_\_\_\_\_  
Notary Public Signature