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.

Participant 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 _____

SEE REVERSE SIDE

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 Benefit 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.

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.

You must sign and date this form in front of a Notary Public - the notary must sign and date the form the same date as the Participant

_____ _____

PARTICIPANT 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