Pipe Fitters Local No. 533 Health and Welfare Plan

8600 Hillcrest Road, Suite A | Kansas City, Missouri 64138 | (p) 816.361.0206 | (f) 816.444.4275

BENEFICIARY DESIGNATION FORM

Please complete this form and mail it to:

Pipe Fitters Local No. 533 Health and Welfare Plan
8600 Hillcrest Road, Suite A
Kansas City, MO 64138

In order to be valid, this form must be completed, signed, and received by the Plan Administrator prior to the death of the Participant.

Note: If you designate your spouse as your Beneficiary, the Beneficiary designation shall automatically become null and void upon divorce. In the event you designate your spouse and another individual as your Designated Beneficiaries, only the portion of the Beneficiary Designation that relates to your spouse will automatically become null and void upon divorce. If you get divorced and you want your ex-spouse to remain your Designated Beneficiary, you must file a new Beneficiary Designation Form with the Fund Office after your divorce.

____
Participant's Full Name Date of Birth

____
Street Address City State Zip

- -
____
Social Security Number Marital Status Gender

Please list your Primary Beneficiary(ies) and Secondary Beneficiary(ies) (if applicable) and provide all of the information requested below for each Beneficiary. Your Primary Beneficiar(ies) is the person(s) who will receive your Death Benefit if (s)he is alive at the time of your death. If you name more than one Primary Beneficiary, you should specify the percentage of your Death Benefit that you would like to allocate to each Primary Beneficiary. The total percentage for your Primary Beneficiary(ies) must equal 100%.

Your Secondary Beneficiary(ies) is the person who will receive your Death Benefit if your Primary Beneficiary(ies) does not survive you (or, if your only Primary Beneficiary is your ex-spouse and the designation is void because of your divorce). If you name more than one Secondary Beneficiary, you should specify the percentage of your Death Benefit that you would like to allocate to each Secondary Beneficiary. The total percentage for your Secondary Beneficiary(ies) must equal 100%.

Primary Beneficiary(ies)

Name_________________________________

Social Security #___________________________

Percentage___________%

Relationship______________________________

____
Street Address

____
City State Zip

Name_________________________________

Social Security #___________________________

Percentage___________%

Relationship______________________________

____
Street Address

____
City State Zip

Secondary Beneficiary(ies)

Name_________________________________

Social Security #___________________________

Percentage___________%

Relationship______________________________

____
Street Address

____
City City Zip

Name_________________________________

Social Security #___________________________

Percentage___________%

Relationship______________________________

____
Street Address

____
City State Zip

____
Participant's Signature Date

Please keep a copy of this form for your records and return the original to the Fund Office.