BENEFICIARY FORM
IBEW LOCAL UNION 124 FRINGE BENEFIT FUND
HEALTH & WELFARE, PENSION, ANNUITY, VACATION AND HOLIDAY, 401k
305 E 103RD TERR, KANSAS CITY, MO 64114
816-943-0277

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LAST NAME FIRST NAME MIDDLE NAME SOCIAL SECURITY NUMBER(SSN)

Marital Status ____Single ____Married Birthday______________________________

I hereby designate the following beneficiary for any benefits due from the above Trust Fund(s) upon my death. Please see below for suggested beneficiary designations. If you need additional space, please attach.

PRIMARY BENEFICIARY(IES)

____

LAST NAME FIRST NAME SSN RELATIONSHIP PHONE# %

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LAST NAME FIRST NAME SSN RELATIONSHIP PHONE# %

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LAST NAME FIRST NAME SSN RELATIONSHIP PHONE# %

ALTERNATE BENEFICIARY(IES)

If all beneficiaries designated above die before I do, then I name as alternate beneficiary(ies)

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LAST NAME FIRST NAME SSN RELATIONSHIP PHONE# %

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LAST NAME FIRST NAME SSN RELATIONSHIP PHONE# %

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LAST NAME FIRST NAME SSN RELATIONSHIP PHONE# %

If none of the beneficiaries designated above are living at the time any benefits is due or unpaid, the benefit is to be paid as directed by the Plan. This beneficiary designation revokes any prior designation I may have made.

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PARTICIPANT SIGNATURE DATE