Plumbers and Steamfitters Local 577
Health & Welfare, Annuity and Pension Funds

230 Lexington Green Circle • Suite 400
Lexington, Kentucky 40503
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: ☐ Male ☐ Female ☐ Married ☐ Single

TELEPHONE: _____
Work Home Cell

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

IMPORTANT INFORMATION ABOUT YOUR BENEFICIARY DESIGNATIONS: Use this form to designate or update the beneficiary(ies) of your Plumbers and Steamfitters Local Union No. 577 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. 577 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. 577 Health and Welfare Fund.**

Please note you must be an eligible active employee under the Plumbers and Steamfitters Local Union No. 577 Health and Welfare Fund at the time of death in order to be eligible for this 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.

CHECK ONE: ☐ **Initial Election** ☐ **Beneficiary Change**

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

Last Name _____ First Name _____ Middle Initial _____

CHECK ONE:

☐ **Primary** **RELATIONSHIP TO EMPLOYEE:** _____ **% OF BENEFIT:** _____ %

☐ **Co-Primary** **RELATIONSHIP TO EMPLOYEE:** _____ **% OF BENEFIT:** _____ %

☐ **Contingent** **RELATIONSHIP TO EMPLOYEE:** _____ **% OF BENEFIT:** _____ %

☐ **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.*

Last Name _____ First Name _____ Middle Initial _____

CHECK ONE:

☐ **Primary** **RELATIONSHIP TO EMPLOYEE:** _____ **% OF BENEFIT:** _____ %

☐ **Co-Primary** **RELATIONSHIP TO EMPLOYEE:** _____ **% OF BENEFIT:** _____ %

☐ **Contingent** **RELATIONSHIP TO EMPLOYEE:** _____ **% OF BENEFIT:** _____ %

☐ **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.*

Last Name | First Name | Middle Initial

CHECK ONE:

☐ **Primary**	**RELATIONSHIP TO EMPLOYEE:**	**% OF BENEFIT:**	%
☐ **Co-Primary**	**RELATIONSHIP TO EMPLOYEE:**	**% OF BENEFIT:**	%
☐ **Contingent**	**RELATIONSHIP TO EMPLOYEE:**	**% OF BENEFIT:**	%
☐ **Co-Contingent**	**RELATIONSHIP TO EMPLOYEE:**	**% OF BENEFIT:**	%

ADDRESS: Street | City | Zip Code

AUTHORIZATION/SIGNATURE: I authorize the Plumbers and Steamfitters Local Union No. 577 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. 577 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. 577 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:

ATTN: Taft-Hartley Eligibility Department
Plumbers & Steamfitters Local Union No. 577 Health & Welfare Fund
230 Lexington Green Circle, Suite 400
Lexington, KY 40503