

Beneficiary Designation Form (W) (WASB)

PLUMBERS LOCAL UNION No.1 WELFARE FUND

50-02 5th Street, Long Island City, New York, 11101
Tel. (718) 835-2700

Welfare Fund

(A) Member Information

Use a ballpoint pen to complete form

- - (2) Last (3) First (4) Init
 (5) Street (6) City (7) State (8) Zip
 - - (9) Date of Birth (10) Sex M F (11) Home Phone Number/Cell Number
 (12) E-mail Address
 (13) Retired (14) Active (15) Emergency Contact (16) Emergency Contact Phone Number/Cell Number

(B) Primary Beneficiary for Death Benefits for the Welfare Fund Life Insurance and Additional Security Benefit Account: I hereby designate the following person(s) as my Primary Beneficiary(ies) to receive benefits, if any, payable at my death. You may attach a second form if you wish to name more beneficiaries. **(Note: Beneficiary percentage may be split, but must total 100 percent).**

Name(s) of Primary Beneficiary(ies)		Percentage	Date of Birth	Social Security Number	Relationship to Member
Last	First Init.	(0% to 100%)			
(1)	1			<input type="text"/> - <input type="text"/> - <input type="text"/>	
(1a) Address					
(2)	2			<input type="text"/> - <input type="text"/> - <input type="text"/>	
(2a) Address					

(C) Contingent Beneficiary for Death Benefits for the Welfare Fund Life Insurance and Additional Security Benefit Account: If all of the above Beneficiary(ies) do not survive, I hereby designate the following person(s) to be my Contingent and Successor Beneficiary(ies) to receive any benefits that become due as a result of my death or which remain payable after the death of (all) the above named beneficiary(ies). **(Note: Beneficiary percentage may be split, but must total 100 percent).**

Name(s) of Primary Beneficiary(ies)		Percentage	Date of Birth	Social Security Number	Relationship to Member
Last	First Init.	(0% to 100%)			
(1)	1			<input type="text"/> - <input type="text"/> - <input type="text"/>	
(1a) Address					
(2)	2			<input type="text"/> - <input type="text"/> - <input type="text"/>	
(2a) Address					
(3)	3			<input type="text"/> - <input type="text"/> - <input type="text"/>	
(3a) Address					
(4)	4			<input type="text"/> - <input type="text"/> - <input type="text"/>	
(4a) Address					

(D) Authorization: You may amend or revoke your designation at any time by filing another form.

Member Signature: _____ **Date:** - -
 I understand that distribution of benefits to my designated beneficiary(ies) shall be made in accordance with the terms of the Plan. I also understand that this beneficiary form supersedes any beneficiary designation currently in effect.

If your Beneficiary should die while receiving benefits and further payments are due for periods after death, such payments shall be made to your Beneficiaries designated Beneficiary(ies).

If you fail to designate a beneficiary or if all designated Beneficiaries die or are invalidated and you die without having received the distribution of your account balance, the account balance will be distributed in the following order: your surviving spouse (or the surviving spouse of your Beneficiary if your Beneficiary is receiving benefits); your children (or the children of your Beneficiary if your Beneficiary is receiving benefits); your parents (or the parents of your Beneficiary if your Beneficiary is receiving benefits); your brothers and sisters (or the brothers and sisters of your Beneficiary); or the personal representative of your estate or your Beneficiary's estate if your Beneficiary is receiving benefits. If there is more than one individual in a category, the benefit will be divided equally among them unless you state otherwise in your beneficiary designation.

NOTE: PLEASE MAKE A COPY OF THE FORM FOR YOUR PERSONAL RECORDS.

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