IBEW LOCAL 96
ANNUITY, PENSION & HEALTH & WELFARE FUNDS
ALL PURPOSE BENEFICIARY FORM

Participant's Last Name First Middle

DAVID KENNETH

Home Address, Number and Street

City, Town State Zip

Home Phone No:

Cell Phone No:

Email Address:

Date of Birth Month Day Year	Social Security	
Date of Marriage	Date of Hire	Home Local

Please check applicable boxes:

❒ Male ❒ Female	❒ Single ❒ Married ❒ Legally Separated	❒ Widowed ❒ Divorced

IMPORTANT – If married, you may **NOT** designate a beneficiary other than your spouse under the Annuity and Pension Funds without your spouse's notarized consent (contact the Fund Office for special instructions - completion of this form alone will not suffice).

List below name(s) of husband or wife and children under 26 years old.

Name	SS No.	Date of Birth
Spouse:	/ /	/ /
Dependent:	/ /	/ /
	/ /	/ /
	/ /	/ /

Multiple Beneficiaries – If you would like to designate more than one Beneficiary to share benefits, indicate on this form by checking the box below, indicate all beneficiaries on reverse side and provide NAME, SS#, DATE OF BIRTH, ADDRESS AND APPLICABLE FUNDS, and sign page 2 also. ☐

Please complete all sections and sign below. For additional information, please see below.

ANNUITY FUND BENEFICIARY

Name of **PRIMARY** Beneficiary SS No. Last 4:

Relationship: DOB / /

Address of PRIMARY Beneficiary

Name of Contingent Beneficiary# SS No. Last 4:

PENSION FUND BENEFICIARY

Name of **PRIMARY** Beneficiary* SS No. Last 4:

Relationship: DOB / /

Address of PRIMARY Beneficiary

Name of Contingent Beneficiary# SS No. Last 4:

HEALTH & WELFARE FUND BENEFICIARY

Name of **PRIMARY** Beneficiary SS No. Last 4:

Relationship: DOB / /

Address of PRIMARY Beneficiary

Name of Contingent Beneficiary# SS No. Last 4:

Additional Information

***IMPORTANT** – If **married**, you may **NOT** designate a beneficiary other than your spouse under the Annuity and Pension Funds without your spouse's notarized consent (contact the Fund Office for special instructions – completion of this form alone will not suffice).You may designate anyone for the Health & Welfare Fund Life Insurance and any other benefits.

#Contingent Beneficiary – A Contingent Beneficiary would ONLY receive benefits if the Primary Beneficiary is deceased.

If you should have any questions, please call or write the Fund Office. Please be sure to **complete all sections** and return to IBEW Local 96 FUNDS OFFICE, P.O. BOX 5817, Wallingford, CT 06492-7617 – Telephone: (800) 446-8646.

Signature (full name) Date PARTICIPANT

Witness (not a relative) or Notary's Signature Date WITNESS

IMPORTANT: The most current Form on file with the Funds Office supersedes all previous beneficiary designations for the Annuity, Pension, Health & Welfare Funds.

ADDITIONAL BENEFICIARIES

THESE BENEFICIARIES WILL SHARE EQUALLY WITH THOSE LISTED ON PAGE 1 OF THIS FORM

ANNUITY FUND BENEFICIARY

Name of **PRIMARY** Beneficiary SS No. Last 4:

Relationship: DOB / /

Address of PRIMARY Beneficiary

Name of Contingent Beneficiary# SS No. Last 4:

PENSION BENEFICIARY

Name of **PRIMARY** Beneficiary* SS No. Last 4:

Relationship: DOB / /

Address of PRIMARY Beneficiary

Name of Contingent Beneficiary# SS No. Last 4:

HEALTH & WELFARE BENEFICIARY

Name of **PRIMARY** Beneficiary SS No. Last 4:

Relationship: DOB / /

Address of PRIMARY Beneficiary

Name of Contingent Beneficiary# SS No. Last 4:

Signature Date