

OPERATING ENGINEERS TRUST FUNDS

I.U.O.E. LOCAL 12 HEALTH & WELFARE / PENSION / VACATION / DCP

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OPERATING ENGINEERS LOCAL 12 DEFINED CONTRIBUTION PLAN BENEFICIARY DESIGNATION

A. PARTICIPANT INFORMATION: (please print clearly)

Last Name First Name MI

Address (No. & Street) (City) (State) (Zip)

SSN Phone No. Date of Birth

Marital Status (Check one)

Married Single

IMPORTANT: If no valid beneficiary designation is on file or if designation cannot otherwise be determined, beneficiary will be determined by the plan fiduciary according to plan documents and applicable law.

This designation supersedes any prior designation.

B. PRIMARY BENEFICIARY: (check appropriate box)

Spouse Primary Beneficiary: I designate my spouse to receive my entire account balance upon my death.

Spouse Name SSN Date of Birth

Non-Spouse or Multiple Primary Beneficiaries: I designate the following person(s) to receive my account balance upon my death: [Up to 3 decimals may be entered when assigning percentages (e.g., 33.333%, 33.334%, etc.), but **the total for all primary beneficiaries must equal 100%.**]

Name	Relationship	SSN	Percent
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you are married and you have not designated your spouse as primary beneficiary, please have your spouse provide consent below.

SPOUSAL CONSENT: I understand I have a legal right to a death benefit equal to the participant's entire account balance. I consent to waive that legal right in accordance with the beneficiary designation set forth above. I acknowledge that I have a right to limit my consent only to a specific beneficiary and that I voluntarily elect to relinquish such right. I further understand and acknowledge that if I sign this form, no death benefit will be payable to me except as provided above.

Spouse's Signature Date

The spouse's signature must be witnessed by a Notary Public:

Notary Public:

Notarization of spousal consent can be signed off by a Notary Public. A Notary Seal is not required when participant resides in one of the following states: CT, KY, LA, ME, MI, NJ, NY, RI, VT

C. CONTINGENT BENEFICIARY: (optional)

Contingent Beneficiary (optional): If no Primary Beneficiary listed herein is alive upon my death, I designate the following person(s) to receive my account balance upon my death. [Up to 3 decimals may be entered when assigning percentages (e.g., 33.333%, 33.334%, etc.), but **the total for all contingent beneficiaries must equal 100%.**]

Name	Relationship	SSN	Percent
Name	Relationship	SSN	Percent
Name	Relationship	SSN	Percent
Name	Relationship	SSN	Percent

D. PARTICIPANT SIGNATURE:

Participant's Signature

Date