Benefit Services
SERVING LOCAL UNION 725 & MCASF
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MCASF Local 725 Health and Welfare Trust Fund
BENEFICIARY ELECTION FORM

Member's Name_____ SSN_____

Address _____

Below, please indicate the person(s) you wish to be named as beneficiary(ies) of any death benefits through the MCASF Local 725 Health & Welfare Trust Fund.

NOTE: If you are legally married at the time of your death, Federal law and the Benefit Fund requires that benefits be paid to your surviving spouse, unless your spouse consents to the payment of the benefit to someone else. To make that type of change, the Benefit Fund will require a notarized statement from your spouse – see bottom of this form for notarized consent by your spouse.

BENEFICIARY DESIGNATION_____

Primary Beneficiary _____ SSN _____
Percentage of Benefit _____ Relationship _____
Address _____

Primary Beneficiary _____ SSN _____
Percentage of Benefit _____ Relationship _____
Address _____

In the event your Primary Beneficiary(ies) pre-deceases you, the below list of Contingent Beneficiary(ies) will be paid based on the percentage you indicate.

Contingent Beneficiary _____ SSN _____
Percentage of Benefit _____ Relationship _____
Address _____

Contingent Beneficiary _____ SSN _____
Percentage of Benefit _____ Relationship _____
Address_____

(Attach additional paper if necessary, please ensure to indicate "primary" or contingent" and percentage)

I understand that this beneficiary designation cancels any previous designation I may have made and will be effective when received in the Fund Office and only if received prior to my death. Further, I understand that this designation shall be cancelled if my current marriage ends and I remarry, which would make my legal spouse at the time of my death my new beneficiary.

Member's Signature _____ Date _____ SIGN HERE

SPOUSAL CONSENT OF ALTERNATE BENEFICIARY DESIGNATION AS NOTE ABOVE_____

I hereby consent to my spouse's designation of the above beneficiary for death benefits payable through the Benefit Fund. I fully understand that by signing below, I will not be eligible for the receipt of the benefits payable on behalf of my spouse in the event of his or her death.

Spouse's Signature _____
Date _____

Subscribe to and sworn to before me,
this _____ day of _____, 20_____
Notary Public Signature _____
County of _____ State of _____
My Commission expires _____