IUOE LOCAL 4 HEALTH & WELFARE, PENSION AND ANNUITY & SAVINGS FUNDS
PARTICIPANTS AND BENEFICIARIES FORM

Please fill out this form, sign and date it, and deliver it to the Funds Office. To make any changes, you must submit a new signed and dated form to the Funds Office. If you have any questions, please contact the Funds Office.

1. MEMBER DEMOGRAPHICS (PLEASE PRINT)

First Name	Middle	Last	Suffix	Gender M / F	Date of Birth	Social Security#
Mailing Address		City		State	Zip	Home Phone#
Email Address		Union Register#		Home Local	Initiation Date	Cell Phone#

2. MARITAL AND PARENTAL STATUS FOR HEALTH PLAN COVERAGE

Please note that all dependents must meet the eligibility criteria in the Health Fund Summary Plan Description.

Marital Status: (Please check only one)

☐ Married ☐ Never Married ☐ Legally Separated ☐ Divorced (must submit court documents) ☐ Widowed ☐ Divorced & Remarried

DEPENDENT 1 (Please check only one if applicable)
☐ Legal Spouse ☐ Ex-Spouse (court-ordered only)

First Name	Middle	Last	Suffix	Gender M / F	Date of Birth	Social Security#
Marriage Date:	If Divorced, Date of Divorce:		Phone#:		Email Address:	
Mailing Address (Dependent's address if different from Member's)			City		State	Zip

DEPENDENT 2 (Please check only one)
☐ Child ☐ Stepchild ☐ Legal Guardian/Foster Child ☐ Legally Adopted Child ☐ 26 or Older and Totally Disabled

First Name	Middle	Last	Suffix	Gender M / F	Date of Birth	Social Security#
Mailing Address (Dependent's address if different from Member's)			City		State	Zip

DEPENDENT 3 (Please check only one)
☐ Child ☐ Stepchild ☐ Legal Guardian/Foster Child ☐ Legally Adopted Child ☐ 26 or Older and Totally Disabled

First Name	Middle	Last	Suffix	Gender M / F	Date of Birth	Social Security#
Mailing Address (Dependent's address if different from Member's)			City		State	Zip

DEPENDENT 4 (Please check only one)
☐ Child ☐ Stepchild ☐ Legal Guardian/Foster Child ☐ Legally Adopted Child ☐ 26 or Older and Totally Disabled

First Name	Middle	Last	Suffix	Gender M / F	Date of Birth	Social Security#
Mailing Address (Dependent's address if different from Member's)			City		State	Zip

TURN OVER TO COMPLETE AND SIGN THE FORM

3. YOUR BENEFICARY(IES)

Please review the Summary Plan Descriptions of the Health, Pension, and Annuity Funds for information about your Health Fund Life Insurance and certain death benefits provided by the Pension and Annuity Funds.

Your beneficiary(ies) named below will receive the proceeds of your Health Fund Life Insurance Policy if you are eligible for coverage at the time of your death. Life insurance proceeds will be paid to your designated Beneficiary(ies) regardless of your marital status at the time of your death.

Your beneficiary(ies) named below may be entitled to certain death benefits from the Pension and Annuity Funds unless you have a later designation on file with the Pension and/or Annuity Funds naming a different Beneficiary(ies) that is dated after the date of this form. Regardless of whom you name as your Beneficiary(ies), the Pension and Annuity Funds are obligated to treat your Qualified Spouse as your Beneficiary in the event of your death, unless your Qualified Spouse chooses to waive their rights by signing and delivering a waiver form to the Funds Office. If you designate an ex-spouse as your Beneficiary, the Pension and Annuity Funds will presume that your designation was terminated as of the date of divorce unless your designation is dated after the date of your divorce.

If you name more than one Primary Beneficiary, the total percentage of all Primary Beneficiaries must equal 100%. If you name Secondary Beneficiary(ies), the Secondary Beneficiary(ies) will only be entitled to the proceeds if all of the Primary Beneficiary(ies) predecease you. If only one of your Primary Beneficiaries survives you, that Primary Beneficiary will receive 100% of the proceeds. If you name a minor, proof of guardianship may be required.

PRIMARY BENEFICIARY A:

First Name	Middle	Last	Suffix	Date of Birth	Social Security#
Mailing Address		City	State	Zip	Phone#
Percentage: (Please check only one) ☐ 100% ☐ 50% ☐ Other (specify amount: _____)		Email		Relation	

PRIMARY BENEFICIARY B:

First Name	Middle	Last	Suffix	Date of Birth	Social Security#
Mailing Address		City	State	Zip	Phone#
Percentage: (Please check only one) ☐ 100% ☐ 50% ☐ Other (specify amount: _____)		Email		Relation	

SECONDARY BENEFICIARY A:

First Name	Middle	Last	Suffix	Date of Birth	Social Security#
Mailing Address		City	State	Zip	Phone#
Percentage: (Please check only one) ☐ 100% ☐ 50% ☐ Other (specify amount: _____)		Email		Relation	

SECONDARY BENEFICIARY B:

First Name	Middle	Last	Suffix	Date of Birth	Social Security#
Mailing Address		City	State	Zip	Phone#
Percentage: (Please check only one) ☐ 100% ☐ 50% ☐ Other (specify amount: _____)		Email		Relation	

Please contact the Funds Office if you would like to add additional dependents or beneficiaries.

UNDER PENALTIES OF PERJURY, I DECLARE THAT THE INFORMATION I HAVE FURNISHED ABOVE, TO MY KNOWLEDGE AND BELIEF, IS TRUE AND COMPLETE.

MEMBER SIGNATURE

DATE SIGNED

Return Form to:
IUOE Local 4 Benefit Funds Office, 16 Trotter Drive, PO Box 680, Medway, MA 02053