

# HEALTH & SECURITY LIFE and AD&D BENEFICIARY FORM

FOR LU 367, LU 262 & SHAW MEMBERS ONLY

ALASKA PIPE TRADES UA LOCAL 367 HEALTH & SECURITY TRUST

610 W. 54th Avenue \* Anchorage AK 99518-1137 \* Phone: 907-562-2810 \* Fax: 907-562-2479

This form is used to designate the beneficiary for an Active member's Life and Accidental Death & Dismemberment (AD&D) Insurance coverage that is an included benefit under the member's Alaska Pipe Trades UA Local 367 Health & Security Plan.

Spouses, Dependent Children, Retirees & COBRA participants do not have this coverage.

This form will supercede all previously completed beneficiary forms with regard to the Alaska Pipe Trades Health & Security policy only. This designation will remain in effect as long as the policy is in effect or until superseded by a new designation. This form does not apply to any other coverage or to any pension plans. Please return this completed form to the above address.

**The ORIGINAL signed & witnessed form is required. PLEASE PRINT CLEARLY.**

## MEMBER'S INFORMATION:

FULL NAME (First, Middle, Last): \_\_\_\_\_ GENDER:  Male  Female

SOCIAL SECURITY No: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

MARITAL STATUS:  MARRIED  SINGLE  DIVORCED / LEGALLY SEPARATED

**BENEFITS ON MEMBER ONLY: \$5,000 MAXIMUM LIFE INSURANCE \$5,000 MAXIMUM ACCIDENTAL DEATH & DISMEMBERMENT**

## BENEFICIARY DESIGNATION: (See below for definitions\*)

### BENEFICIARY # 1

Full Name (First, Middle, Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

Primary Beneficiary\*:  or Contingent Beneficiary\*:  % of Benefit: \_\_\_\_\_

### BENEFICIARY # 2

Full Name (First, Middle, Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

Primary Beneficiary\*:  or Contingent Beneficiary\*:  % of Benefit: \_\_\_\_\_

### BENEFICIARY # 3

Full Name (First, Middle, Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

Primary Beneficiary\*:  or Contingent Beneficiary\*:  % of Benefit: \_\_\_\_\_

### BENEFICIARY # 4

Full Name (First, Middle, Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_

Primary Beneficiary\*:  or Contingent Beneficiary\*:  % of Benefit: \_\_\_\_\_

## \*DEFINITIONS:

**Primary Beneficiary** - The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit. The total percentage for all Primary Beneficiaries can not exceed 100%.

**Contingent Beneficiary** - The person or persons you want to receive the life insurance benefits if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit. The total percentage for all Contingent Beneficiaries can not exceed 100%.

**Please read the following notice that we are required by law to give to you.**

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, is guilty of a felony and is subject under state law to prosecution and punishment, including fines and / or imprisonment. Submission of false information in connection with this claim form may also constitute a crime under federal law. All appropriate legal remedies will be pursued in the event of insurance fraud, including prosecuting under Federal Mail Fraud, Federal Wire Fraud, and/or Federal Racketeer Influenced and Corrupt Organizations Act Statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness's Signature: \_\_\_\_\_

Witness's Printed Name: \_\_\_\_\_