HEALTH & SECURITY LIFE and AD&D BENEFICIARY FORM

FOR LU 367 & LU 262 MEMBERS ONLY

ALASKA PIPE TRADES UA LOCAL 367 HEALTH & SECURITY TRUST
610 W. 54th Avenue * Anchorage AK 99518-1137 * Phone: 907-562-2810 * Fax: 907-562-0467

This form is used to designate the beneficary 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 This designation will remain in effect as long as the policy is in effect or until superseded by a new designation.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 Beneficary*: ☐ **or** Contigent Beneficiary*: ☐ % of Benefit: _____

BENEFICIARY # 2

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

Address: _____

Relationship to Member: _____

Primary Beneficary*: ☐ **or** Contigent Beneficiary*: ☐ % of Benefit: _____

BENEFICIARY # 3

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

Address: _____

Relationship to Member: _____

Primary Beneficary*: ☐ **or** Contigent Beneficiary*: ☐ % of Benefit: _____

BENEFICIARY # 4

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

Address: _____

Relationship to Member: _____

Primary Beneficary*: ☐ **or** Contigent 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 beneficary is alive on that date. If more than one contingent benefiticary 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 inprisonment. Submission of false information is 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 procecuting under Federal Mail Fraud, Federal Wire Fraud, and/or Federal Racketeer influenced and Corrupt Organizations Act Statues. 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: _____