Electrical Workers Local 369 Benefit Fund
906 Minoma Avenue
Louisville, KY 40217
(502) 635-2611 or (800) 427-2495

Designating Your Beneficiary

Complete this form to designate the person, persons or legal entity that will receive your Death Benefit if you die.

If you name more than one beneficiary, without specifying shares, the Plan will distribute your benefit in equal shares. You can change your beneficiary anytime by resubmitting this form.

Employee Name		Today's date	
Social Security number		Primary phone number	
Date of birth		Email address	
Home address	City	State	Zip code
Marital status	☐ Not married (single, divorced, widowed)	☐ Married	
Primary Beneficiary			
Social Security number		Primary phone number	
Date of birth		Email address	
Home address	City	State	Zip code
Relationship	Type of beneficiary	Contingent	Joint ______%
Primary Beneficiary			
Social Security number		Primary phone number	
Date of birth		Email address	
Home address	City	State	Zip code
Relationship	Type of beneficiary	Contingent	Joint ______%
Primary Beneficiary			
Social Security number		Primary phone number	
Date of birth		Email address	
Home address	City	State	Zip code
Relationship	Type of beneficiary	Contingent	Joint ______%

In the event that all of the above-named beneficiaries die before the full amount of my benefits, if any, has been paid, I direct that my entire remaining interest in the Fund be paid to the following secondary beneficiary for the percentage indicated (or equally to the following secondary beneficiaries if no percentage is indicated).

Secondary Beneficiary			
Social Security number		Primary phone number	
Date of birth		Email address	
Home address	City	State	Zip code
Relationship	Type of beneficiary	Contingent	Joint ______%
Social Security number		Primary phone number	
Date of birth		Email address	
Home address	City	State	Zip code
Relationship	Type of beneficiary	Contingent	Joint ______%

Electrical Workers Local 369 Benefit Fund
906 Minoma Avenue
Louisville, KY 40217
(502) 635-2611 or (800) 427-2495

Secondary Beneficiary

Social Security number		Primary phone number	
Date of birth		Email address	
Home address	City	State	Zip code
Relationship	Type of beneficiary	Contingent	Joint _____%

I, the undersigned, revoke any and all prior beneficiary designations made by me with respect to the Electrical Workers Local 369 Benefit Fund and direct that any benefits payable under the Plan upon my death be paid to the following primary beneficiary for the percentage indicated (or equally to the following primary beneficiaries if no percentage is indicated).

By signing this form, I affirm that, to the best of my knowledge, the information I am providing is true and accurate. I am aware that the Plan provisions are provided in the Electrical Workers Local 369 Benefit Fund Plan Document. If there is a discrepancy between the wording here and the Plan Document, the language in the Plan Document governs. I acknowledge that the Trustees reserve right to interpret, amend, modify or terminate this Plan or any of the benefits at any time.

Employee signature Date

Contact the Fund Office for more information about your benefits at 502-635-2611 or 800-427-2495.
Return forms and documentation to the Fund Office by mail, fax, or email.

Mail	**Fax**	**Email**
Electrical Workers Local 369 Benefit Fund 906 Minoma Ave. Louisville, KY 40217	502-637-3444	mwendler@369benefits.com