Beneficiary Form

Elevator Constructors Annuity and 401(k) Retirement Plan
60041

GENERAL INFORMATION: Please complete this form, including your signature and the date. Keep a copy for your records. and forward the original to the fund office at the address at the bottom of the page.

SOCIAL SECURITY NUMBER	FIRST NAME	LAST NAME	MI

STREET ADDRESS	E-MAIL ADDRESS

CITY	STATE	ZIP

BIRTH DATE	MARITAL STATUS
	☐ MARRIED ☐ SINGLE OR LEGALLY SEPARATED

BENEFICIARY DESIGNATION (Check one box only)

1. ☐ **Spouse Primary Beneficiary:** I would like my spouse to receive my entire account balance at my death.

   Spouse's Name: _____ Spouse's Social Security # _____-_____-_____ Spouse's Date of Birth:_____/_____/_____ (mo day yr)

2. ☐ **Non-Spouse or Multiple Primary Beneficiaries:** I would like the following person(s) to receive my account balance upon my death:
   (If division is other than equal shares, write in percentages.)

PRIMARY BENEFICIARY NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	PERCENT
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If you are married and you have NOT elected your spouse as primary beneficiary, please have your spouse provide consent below.

SPOUSAL CONSENT: I understand that I have a legal right to a death benefit equal to the participant's entire account balance. I consent to waive that legal right in accordance with the beneficiary designation set forth above. I further understand and acknowledge that if I sign this form, no death benefit will be payable to me except as provided above. I acknowledge that I have a right to limit my consent only to a specific beneficiary and that I voluntarily elect to relinquish such right.

SPOUSE'S SIGNATURE	DATE	NOTARY PUBLIC'S SIGNATURE	DATE	DATE COMMISSION EXPIRES

SECONDARY BENEFICIARY DESIGNATION

SECONDARY BENEFICIARY NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	PERCENT
SECONDARY BENEFICIARY NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	PERCENT

I would like the following person(s) to receive my account balance upon my death and the death of my primary beneficiary(ies).

PARTICIPANT SIGNATURE:

I, the participant, certify that the above information is correct and I understand this beneficiary designation supersedes any previous designation.

PARTICIPANT	DATE

- Retain a copy for your records.
- Provide a copy to your employer.
- **Forward original to:** NEI Benefit Plans, 19 Campus Boulvard, Suite 200, Newton Square, PA 19073.

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