Laborers Local No. 754 Joint Benefit Funds

215 Old Nyack Turnpike • Chestnut Ridge, NY 10977
Phone (845) 425-0210 • FAX (845) 425-1835

DATE:

TO: ALL LABORERS LOCAL NO. 754 PARTICIPANTS

YOUR IMMEDIATE COOPERATION IS REQUESTED IN COMPLETING THIS DATA SPECIFICALLY DESIGNED FOR THE PROTECTION OF YOUR BENEFITS. THIS WILL BE YOUR PERMANENT RECORD SO BE SURE THAT YOU ANSWER ALL QUESTIONS. RETURN THE COMPLETED FORM TO THE FUND OFFICE. UPDATE AS NEEDED. PLEASE COMPLETE THE FORM IN ITS ENTIRETY WHETHER OR NOT YOU ARE PARTICIPATING IN ALL THE FUNDS LISTED.

RETIREE BENEFICIARY FORM

Please Print

NAME_____
LAST FIRST MIDDLE INITIAL

ADDRESS_____

_____ZIP_____

SOCIAL SECURITY NO._____DATE OF BIRTH_____

TELEPHONE NO._____CELL NO._____E-MAIL ADDRESS_____

SEX [ ] MALE [ ] FEMALE

MARITAL STATUS [ ] SINGLE [ ] MARRIED [ ] LEGALLY SEPARTED [ ] WIDOWED [ ] DIVORCED

EFFECTIVE DATE OF CURRENT STATUS:_____

WELFARE-BENEFICIARY NAME_____**SOCIAL SECURITY NO.:**_____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

***PENSION-BENEFICIARY NAME**_____**SOCIAL SECURITY NO.:**_____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

***ANNUITY-BENEFICIARY NAME**_____**SOCIAL SECURITY NO.:**_____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

***IF YOU ARE MARRIED, YOU MUST DESIGNATE YOUR SPOUSE. IN ACCORDANCE WITH FEDERAL LAW, IF YOU ARE A VESTED PARTICIPANT UNDER THE PENSION PLAN AND/OR ANNUITY PLAN, "BENEFICIARY" MEANS YOUR LAWFUL SPOUSE OR, IF THERE IS NO LAWFUL SPOUSE, THE PERSON YOU SPECIFY IN WRITING AS YOUR DESIGNATED BENEFICIARY.**

I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT ANY FALSE INFORMATION MAY DISQUALIFY ME FOR BENEFITS AND THAT THE FUNDS SHALL HAVE THE RIGHT TO RECOVER ANY BENEFIT PAYMENTS MADE BECAUSE OF FALSE INFORMATION.

PENSIONER/RETIREE SIGNATURE_____**DATE**_____

SPOUSE SIGNATURE_____**DATE**_____

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IF YOU WOULD LIKE TO ASSIGN CONTINGENT BENEFICIARIES PLEASE COMPLETE THE FOLLOWING
(This Form will be invalid without a completed Beneficiary Form)

CONTINGENCY BENEFICIARY FORM

Please Print

CONTINGENT WELFARE-BENEFICIARY NAME_____SOCIAL SECURITY NO._____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

CONTINGENT PENSION-BENEFICIARY NAME_____SOCIAL SECURITY NO._____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

CONTINGENT ANNUITY-BENEFICIARY NAME_____SOCIAL SECURITY NO._____

ADDRESS IF NOT YOURS_____

RELATIONSHIP_____DATE OF BIRTH_____TELEPHONE NO._____

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PARTICIPANT SIGNATURE_____**DATE**_____

SPOUSE SIGNATURE_____**DATE**_____

Please complete multiple forms for multiple Contingent Beneficiaries