



Harrison Electrical Workers Trust Fund

Beneficiary Information

Your Harrison Trust Plan includes a Life Insurance Benefit. To properly administer your Life Insurance Plan, we need the following important information. Please complete and return this form in the enclosed envelope and keep a copy for your own records. If at any time you choose to change your designated beneficiary(ies), it is necessary for you to complete a new form. In the event you do not submit this form, benefits will be paid as described in the "Life Insurance / AD&D" section in your Benefits Booklet. *Thank you*

Participant Information

Name: _____

Address: _____
Number Street City State ZIP

Social Security Number: _____ Date of Birth: _____

Primary Beneficiary

(Read Both Sides – Please Print or Type)

Any Life and AD&D Insurance benefits payable due to my death shall be paid to the following individual(s):

Name: _____

Address: _____
Number Street City State ZIP

Social Security Number: _____ Date of Birth: _____

Relationship: _____

_____%
Designated Percentage

Name: _____

Address: _____
Number Street City State ZIP

Social Security Number: _____ Date of Birth: _____

Relationship: _____

_____%
Designated Percentage

Name: _____

Address: _____
Number Street City State ZIP

Social Security Number: _____ Date of Birth: _____

Relationship: _____

_____%
Designated Percentage

THE TOTAL AMOUNT ALLOCATED TO ALL PRIMARY BENEFICIARIES MUST EQUAL 100%

If I have named more than one PRIMARY BENEFICIARY and he/she dies before me, I understand that his/her share will be divided equally among the remaining Primary Beneficiaries.

_____%
TOTAL

Contingent Beneficiaries

If all the PRIMARY BENEFICIARIES die before me, any Life and AD&D Insurance benefits payable due to my death shall be paid to the following individual(s):

Name: _____

Address: _____
Number Street City State ZIP

Social Security Number: _____ Date of Birth: _____

Relationship: _____

Designated Percentage box with % symbol

Name: _____

Address: _____
Number Street City State ZIP

Social Security Number: _____ Date of Birth: _____

Relationship: _____

Designated Percentage box with % symbol

Name: _____

Address: _____
Number Street City State ZIP

Social Security Number: _____ Date of Birth: _____

Relationship: _____

Designated Percentage box with % symbol

THE TOTAL AMOUNT ALLOCATED TO ALL CONTINGENT BENEFICIARIES MUST EQUAL 100%

If I have named more than one CONTINGENT BENEFICIARY and he/she dies before me, I understand that his/her share will be divided equally among the remaining Contingent Beneficiaries.

TOTAL box with % symbol

Participant Signature

Name: _____

Date: _____

Note: Beneficiary Designations are not valid unless this form is signed and dated.

Questions regarding this form?

Call (503) 224-0048 ext. 1679 or Toll Free (800) 547-4457 ext. 1679; or you may visit us on the web at: www.harrison.aibpa.com.