

ILWU-PMA WELFARE PLAN BENEFICIARY DESIGNATION FORM
GENERAL INSTRUCTIONS

1. This form must be completed and signed by the eligible active or retired longshoreman.
2. No Beneficiary Designation Form is effective until it is received by the Trustees.
3. Changes in beneficiary designation may be made at any time by submitting a new Beneficiary Designation Form to the Plan office.
4. The designated beneficiary may be any person or organization **except** and ILWU local, the ILWU International, and Pacific Maritime Association.
5. A longshoreman may designate more than one person or organization as primary beneficiary and specify the percentage of benefits payable to each. Use **Section (i)** to designate a person or organization as primary beneficiary.
6. A longshoreman may designate a Living Trust as primary beneficiary. Before benefits are paid to a Living Trust, certification from the Trustee of the Living Trust will be required that the Living Trust was valid and was not revoked. Use **Section (ii)** to designate a Living Trust as primary beneficiary and provide a copy of the Trust Abstract or signature page as proof of the Trust's validity.
7. A longshoreman may specify a contingency beneficiary to take the place of a primary beneficiary who is deceased or otherwise unqualified to receive the benefit. Use **Section (iii)** to designate a contingency beneficiary if desired.
8. If no valid designation is made, benefits are paid under the laws of the State of California and as provided in the agreement between the Trustees of the Welfare Plan and the Insurance Company.
9. Mail Completed, signed form to:

ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 300
San Francisco, CA 94109

Registration # _____
(for office use only)

ILWU-PMA WELFARE PLAN BENEFICIARY DESIGNATION FORM

Registration No. _____ Local _____ Social Security No. _____ - _____ - _____

Employee or Pensioner Name _____
Last First Middle

I hereby designate the following to receive ILWU-PMA Welfare Plan Program I and II death/accidental death benefits that are payable in the event of my death:

Section (i) - Primary Beneficiary (Person(s) or Organization)

Name	Relationship	Percentage of benefits
_____ Address _____ Street City State Zip Code	_____ Social Security No. _____ - _____ - _____ Date of Birth _____	_____
_____ Address _____ Street City State Zip Code	_____ Social Security No. _____ - _____ - _____ Date of Birth _____	_____
_____ Address _____ Street City State Zip Code	_____ Social Security No. _____ - _____ - _____ Date of Birth _____	_____
_____ Address _____ Street City State Zip Code	_____ Social Security No. _____ - _____ - _____ Date of Birth _____	_____
_____ Address _____ Street City State Zip Code	_____ Social Security No. _____ - _____ - _____ Date of Birth _____	_____
_____ Address _____ Street City State Zip Code	_____ Social Security No. _____ - _____ - _____ Date of Birth _____	_____

**Section (i)
total must
equal 100%**

Section (ii) - Primary Beneficiary (Living Trust)

A copy of Trust Abstract or signature page should be attached to this form. Living Trust must be valid and must not have been revoked.

Name of Trust _____
Date of Trust _____ Trustee _____
Address _____
Street City State Zip Code

Please sign and date the form on page 2

(over)

