MIDWEST OPERATING ENGINEERS
FRINGE BENEFIT FUNDS

Active Welfare Fund
Death Benefit Designation Form

Midwest Operating Engineers
Fringe Benefit Funds Office
6150 Joliet Road
Countryside, IL 60525

MEMBER INFORMATION		
Name:	MOE ID:	
Address:		
City:	State:	Zip Code:
Social Security #:	Date of Birth:	
Phone Number:	Email Address:	

Primary Beneficiary

Members may designate a primary beneficiary(ies) to be the recipient of the Active Employee Death Benefit upon their death. The member must specify the percentage assigned to each primary beneficiary, and **the total percentages must equal 100%**.

A primary/contingent beneficiary may include a person, trust, estate, or other legal entity. The beneficiary designation will become effective on the date the form is received by the Fund Office. Beneficiary designations may be updated at any time through My150 (www.my150.com) under the "My Beneficiaries" tab or by submitting a new designation form. To obtain a new form, call the Member Services Group at 708-579-6600 or visit www.local150.org/moe.

If a primary/contingent beneficiary has not been designated or if they die prior to the member's death, any benefits payable shall be paid according to the Health & Welfare Plan rules (please refer to your Summary Plan Description).

PRIMARY BENEFICIARY DESIGNATION #1		
Full Name:		
Address:		
City:	State:	Zip Code:
Social Security #:	Date of Birth:	
Phone Number:	Relationship:	Percentage

PRIMARY BENEFICIARY DESIGNATION #2		
Full Name:		
Address:		
City:	State:	Zip Code:
Social Security #:	Date of Birth:	
Phone Number:	Relationship:	Percentage

PRIMARY BENEFICIARY DESIGNATION #3		
Full Name:		
Address:		
City:	State:	Zip Code:
Social Security #:	Date of Birth:	
Phone Number:	Relationship:	Percentage

Contingent Beneficiary

Members may designate a contingent beneficiary(ies) to be the recipient of the Active Employee Death Benefit if there are no surviving primary beneficiary(ies). The member must specify the percentage assigned to each contingent beneficiary, and **the total percentages must equal 100%**.

CONTINGENT BENEFICIARY DESIGNATION #1		
Full Name:		
Address:		
City:	State:	Zip Code:
Social Security #:	Date of Birth:	
Phone Number:	Relationship:	Percentage

CONTINGENT BENEFICIARY DESIGNATION #2		
Full Name:		
Address:		
City:	State:	Zip Code:
Social Security #:	Date of Birth:	
Phone Number:	Relationship:	Percentage

CONTINGENT BENEFICIARY DESIGNATION #3		
Full Name:		
Address:		
City:	State:	Zip Code:
Social Security #:	Date of Birth:	
Phone Number:	Relationship:	Percentage

In the event of my death, I hereby designate the individuals on this form as my primary/contingent beneficiary(ies) of my Welfare Fund Active Employee Death Benefit. I reserve the right, without consent of the beneficiary(ies), to further change my beneficiary(ies); subject to any statutory restrictions.

The designation of primary/contingent beneficiary(ies) on this form supersedes all prior primary/contingent beneficiary designations I have made. I understand that it is my responsibility to keep my beneficiary designation information and address up to date.

_____ _____

Member's Signature Date