Please return this entire packet back to IBEW Local #573 union hall office.

IBEW Local #573
4550 Research Parkway NW
Warren, Ohio 44483

If you have any questions, please contact (330) 394-3606.

National Electrical Benefit Fund

ADDRESS CHANGE / CORRECTIONS **(PLEASE PRINT)**

Participant SSN ___ - ___ - ____ Date of Birth ___ / ___ / 19__

Name _____
First Middle Last

NEW ADDRESS INFORMATION

Is this a temporary change of address? ☐ Yes ☐ No

If yes: Start Date ___ / ___ / ___ to End Date ___ / ___ / ___

New Address Line 1

New Address Line 2

City State ZipCode

Phone Number ___ - ___ - ____

OLD ADDRESS INFORMATION

Old Address Line 1

Old Address Line 2

City State ZipCode

Signature

PLEASE do not forget to sign this form.

In the event that the participant is deceased the spouse should also complete the following.

NAME OF SURVIVING SPOUSE _____

Spouse's SSN ___ - ___ - ____ Date ___ / ___ / ____

When you have a change of address, please let us know. Be sure to include your old address and please don't forget to fill in the participant's Social Security Number and Date of Birth. This information will be helpful in checking and keeping our records accurate.

Fax or mail this form to NEBF, 2400 Research Blvd, Suite 500, Rockville, MD 20850-3266. Fax (301)869-4322

50547

IBEW LOCAL NO. 573
PROFIT SHARING PLAN

DEAR PLAN PARTICIPANT:

Please complete this form and return it to our office as soon as possible. This form is very important to you. When completed and signed it will be your beneficiary designation for this local union pension fund. You may change your beneficiary designation at any time. To do so you must file a new beneficiary form with the Fund Office.

PLEASE PRINT:

NAME_____ SOC. SEC.#_____

ADDRESS_____

ZIP CODE_____ HOME PHONE: (____)_____BIRTH DATE_____

MALE ___ FEMALE ___ MARRIED____ SINGLE____

BENEFICIARY(IES) DESIGNATION:

If the Plan Participant is married and the primary beneficiary listed below is NOT the Plan Participant's spouse, the Plan Participant should contact the Fund Office at the phone number listed above to request the Election To Waive Pre-retirement Survivor Annuity Form. If you complete this Beneficiary Form and elect a Primary Beneficiary other than your spouse without obtaining these additional forms, once you return this beneficiary form to the Fund Office, these waiver forms and notices will automatically be sent.

I designate the individual(s) named below as my primary and contingent beneficiary(ies) of this local pension fund. I revoke all prior beneficiary designations, if any, made by me.

PRIMARY BENEFICIARY: NAME_____

SOC. SEC.#_____ RELATIONSHIP_____
ADDRESS_____
CITY_____ STATE_____ ZIP CODE_____
BIRTHDATE___/___/___

CONTINGENT BENEFICIARY If at the time of your death, your primary beneficiary is also deceased, your named contingent beneficiary would become your beneficiary:

NAME_____ SSN#_____
ADDRESS_____
CITY_____STATE_____ZIP CODE_____
RELATIONSHIP_____BIRTHDATE___/___/_____
(Additional Contingent Beneficiaries may be listed on the reverse side)

_____ _____
Signature Date

IBEW LOCAL NO. 573 PENSION PLAN

DEAR PLAN PARTICIPANT:

Please complete this form and return it to our office as soon as possible. This form is very important to you. When completed and signed it will be your beneficiary designation for this local union pension fund. You may change your beneficiary designation at any time. To do so you must file a new beneficiary form with the Fund Office.

PLEASE PRINT:

NAME_____ SOC. SEC.#_____

ADDRESS_____

ZIP CODE_____ HOME PHONE: (____)_____BIRTH DATE_____

MALE ___ FEMALE ___ MARRIED____ SINGLE____

BENEFICIARY(IES) DESIGNATION:

If the Plan Participant is married and the primary beneficiary listed below is NOT the Plan Participant's spouse, the Plan Participant should contact the Fund Office at the phone number listed above to request the Election To Waive Pre-retirement Survivor Annuity Form. If you complete this Beneficiary Form and elect a Primary Beneficiary other than your spouse without obtaining these additional forms, once you return this beneficiary form to the Fund Office, these waiver forms and notices will automatically be sent.

I designate the individual(s) named below as my primary and contingent beneficiary(ies) of this local pension fund. I revoke all prior beneficiary designations, if any, made by me.

PRIMARY BENEFICIARY: NAME_____

SOC. SEC.#_____ RELATIONSHIP_____
ADDRESS_____
CITY_____ STATE_____ ZIP CODE_____
BIRTHDATE___/___/___

CONTINGENT BENEFICIARY If at the time of your death, your primary beneficiary is also deceased, your named contingent beneficiary would become your beneficiary:

NAME_____ SSN#_____
ADDRESS_____
CITY_____STATE_____ZIP CODE_____
RELATIONSHIP_____BIRTHDATE___/___/_____
(Additional Contingent Beneficiaries may be listed on the reverse side)

_____ _____
Signature Date

Mahoning and Trumbull County Building Trades
Insurance Fund

33 Fitch Blvd
Austintown, Ohio 44515

Telephone: 1-800-435-2388
330-270-0453

Enrollment Form

If this form is to change current information, mark type of change below:

Add dependents_____ Change address _____ Delete Dependents_____

Change Beneficiary _____

Please complete and return this form to assure enrollment or that your changes are processed. If additional documentation or information is needed, you will be notified:

Local Number: _____

Member Name: _____

Social Security: _____

Address: _____

_____

Phone Number: _____

Date of Birth: _____

Sex: _____

Marital Status: _____

Spouse Name: _____

Date of Marriage: _____

Social Security No. _____

Date of Birth: _____

Sex: _____

OVER

Dependent Name: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

Dependent Name: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

Dependent Name: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

Dependent Name: _____

Relationship to Member: _____

Date of Birth: _____

Sex: _____

Social Security: _____

Are any family members covered by another group health plan? ___Yes _____No

DEATH BENEFIT INFORMATION

Name _____SSN#:_____

Relationship:_____

Address:_____

Intentionally withholding or falsifying information requested on the form may result in loss of coverage for you and your dependents.

Member
Signature:_____Date:_____