

# **NYC SEIU LOCAL 246 ANNUITY FUND**

## **\*\*\* EXPLANATION OF DEATH BENEFITS AND \*\*\* BENEFICIARY DESIGNATION FORM**

**THIS FORM CONTROLS THE DEATH BENEFIT DISTRIBUTION OF THE ANNUITY FUND ONLY**  
Separate Designation Forms are required for other Benefits  
that may be available through the NYC SEIU Local 246 Active or Retiree Welfare Fund

Dear Member:

It is **essential** that you take the time now to designate a beneficiary for your Annuity Fund (the "Fund") benefits should you die as a participant in the Fund. If you do not do so, the benefit will be distributed in accordance with the Plan Document.

In order to designate a beneficiary to receive any Annuity Fund benefits payable in the event of your death or to update your beneficiary designation, **you must complete, sign and date the Beneficiary Designation Form on the reverse side of this notice and return it to NYC S.E.I.U. LOCAL 246 Annuity Fund c/o Administrative Services Only, Inc., 303 Merrick Road, P.O. Box 9010, Lynbrook, NY 11563-9010.**

**These instructions will assist you in properly completing the Primary and Contingent Beneficiary sections of the Beneficiary Designation Form.**

1. To designate one or more beneficiaries, insert the(ier) name(s), relationship (for example, spouse, son/daughter, sister/brother, friend, etc.), social security number, address, and telephone number.
  - When multiple beneficiaries are named, benefits will be paid in **equal** shares to all surviving beneficiaries. (e.g. if two (2) beneficiaries are named, each beneficiary will receive 50%)
  - Contingent Beneficiaries only receive benefits if **NO** Primary Beneficiary is alive at the time of your death.
2. If you wish to name your estate, insert "Estate" in the blank space.
3. If you wish to designate a Trust, insert the name of the Trustee and Trust in the blank space using language substantially as follows:
  - To X Bank as Trustee, or its successor Trustee, of the John E. Jones Trust dated the \_\_\_ day of \_\_\_\_\_, 20\_\_\_, including any amendments to the Trust.
4. Your Beneficiary's rights to receive benefits are effective **only** if any Annuity Fund benefits you have accumulated remain in the Fund at the time of your death and have not previously been paid to you.
5. The validity of your designation under the law is **YOUR** responsibility. Be precise and clear. You should see an attorney if you require legal advice on your beneficiary designation.
6. You may change a Beneficiary Designation **at any time.**

If you have any questions, please call 877-999-3555 (Toll Free)

**Sincerely,  
Board of Trustees**



# NYC SEIU LOCAL 246 ANNUITY FUND

## \*\*\* BENEFICIARY DESIGNATION FORM \*\*\*

**PLEASE FULLY COMPLETE AND SIGN THIS FORM IN INK AND RETURN TO:**

Administrative Services Only, Inc.  
303 Merrick Rd., PO Box 9010  
Lynbrook, NY 11563-9010

(877) 999-3555 (Toll Free)

### SECTION I MEMBER INFORMATION

LAST NAME	FIRST NAME	MI	SOC SEC NO. Last 4 Digits XXX-XX-	DATE OF BIRTH (Month/Yr)
ADDRESS	APT NO.	CITY	STATE	ZIP
HOME PHONE	EMAIL	OFFICE PHONE	EMPLOYING AGENCY	

### SECTION II PRIMARY BENEFICIARY INFORMATION

I hereby designate the person or persons named below as my Primary Beneficiary(ies) to receive any death benefits payable as a result of my membership in the **NYC SEIU LOCAL 246 Annuity Fund** (hereinafter "Plan"). If designating more than one primary beneficiary, benefits will be paid in **equal** shares to the surviving beneficiary(ies).

FULL NAME – LAST, FIRST, MI	RELATIONSHIP (need not be a family member)	SOC. SEC. NO. (Last 4 Digits)	FULL ADDRESS-CITY, ST & ZIP	DATE OF BIRTH (Month/Yr)	TELEPHONE
		XXX-XX-			
		XXX-XX-			
		XXX-XX-			
		XXX-XX-			

### SECTION III CONTINGENT BENEFICIARY INFORMATION

I hereby designate the person or persons named below as my Contingent Beneficiary(ies) to receive the death benefits described above. Such death benefit will only be payable to my Contingent Beneficiary(ies) so designated, if they are alive at the time of my death **and if NO Primary Beneficiary is alive at the time of my death**. If designating more than one contingent beneficiary, benefits will be paid in **equal** shares to the surviving beneficiary(ies).

FULL NAME – LAST, FIRST, MI	RELATIONSHIP (need not be a family member)	SOC. SEC. NO. (Last 4 Digits)	FULL ADDRESS-CITY, ST & ZIP	DATE OF BIRTH (Month/Yr)	TELEPHONE
		XXX-XX-			
		XXX-XX-			
		XXX-XX-			
		XXX-XX-			

### SECTION IV MEMBER AUTHORIZATION (THIS FORM MUST BE SIGNED AND WITNESSED)

I reserve the right to revoke the designation made herein and to designate another (other) beneficiary(ies). Any such change shall be effective only if I make it in writing and it is actually received by the Trustees prior to my death. I hereby revoke any beneficiary designations made by me prior to the date of this designation. I hereby authorize payment to the beneficiary(ies) whom I have designated above and agree, on behalf of myself and my heirs, that payment so made shall be a complete discharge of the claim and shall constitute a release of the Plan from any further obligation.

\*\*\* Form must be witnessed by a person NOT named as a beneficiary or contingent beneficiary \*\*\*

Member Signature:	Date:	Witness Signature:	Date:
Member Name (Print):		Witness Name (Print):	