Northern Illinois Annuity Fund

EMPLOYER TRUSTEES:
MICHAEL LEOPARDO
JOEL SJOSTROM
GLEN L. TURPOFF
CHRISTOPHER WOOD

Physical: 7525 SE 24th St, Ste 200, Mercer Island, WA 98040
Mailing: PO Box 34203, Seattle, WA 98124
Phone: (206) 441-7574 or (800) 732-1121
Fax: (206) 695-0984
Website: www.niannuityfund.com

LABOR TRUSTEES:
FRANK HOVAR, CHAIRMAN
KEVIN DALE
KEN DIEHL
BRAD LONG
FORTUNATO SALAMONE
JOSE ZAMARRIPA, JR

Administered by
Welfare and Pension Administration Services, Inc.

DESIGNATION OF BENEFICIARY

(Please Print or Type)

I ______________________________ name the following as my beneficiary to receive my account balance, if any, after my death.

PRIMARY BENEFICIARY

NAME: ______________________________ RELATIONSHIP: ____________
(Last) (First) (Middle)

ADDRESS: ____
(Street) (City) (State) (Zip)

SOCIAL SECURITY NUMBER: ____________________ BIRTH DATE: ____________

ALTERNATIVE BENEFICIARY (IF PRIMARY BENEFICIARY PRE-DECEASES ME)

NAME: ______________________________ RELATIONSHIP: ____________
(Last) (First) (Middle)

ADDRESS: ____
(Street) (City) (State) (Zip)

SOCIAL SECURITY NUMBER: ____________________ BIRTH DATE ____________

EMPLOYEE'S INFORMATION

EMPLOYEE'S BIRTH DATE: ____________________ EMPLOYEE'S SS#: ____________

EMPLOYEE'S ADDRESS: ____
(Street) (City) (State) (Zip)

EMPLOYEE'S SIGNATURE: ____________________ DATE SIGNED ____________

SPOUSAL ACKNOWLEDGEMENT OF BENEFICIARY

I, ________________________________ swear that I am the legal spouse of the aforementioned employee. I understand that by signing this document I am consenting to ____________________________ being named as my spouse's primary beneficiary entitled to receive the benefits due my spouse as a participant in the Northern Illinois Annuity Fund in the event of his/her death.

SPOUSE'S SIGNATURE____

State of ____________)

) SS

County of ___________)

I, __________________________, in and for, and residing in the said County in the State aforesaid. DO HEREBY CERTIFY, that ________________________________personally. known to me to be the same person whose name is subscribed above appear before me this day in person, and acknowledged that (s)he signed, sealed and delivered this document as his/her free and voluntary act, for the uses and purposes therein set forth.

Given under my hand and seal this ____ day of ______________________, 20________ (SEAL)

_____________________________My commission expires______________________

NOTARY PUBLIC SIGNATURE

PLEASE COMPLETE BOTH PARTS OF CARD

LAST NAME	FIRST NAME			MIDDLE NAME		LOCAL UNION NO.
HOME ADDRESS	CITY	STATE	ZIP CODE	MARRIED	SINGLE	DATE OF BIRTH (MM/DD/YYYY)
SOCIAL SECURITY NUMBER	UNION MEMBERSHIP NUMBER				DATE FIRST JOINED LOCAL UNION	

PRIMARY DEATH BENEFIT BENEFICIARY INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP
ADDRESS	CITY	STATE	ZIP CODE

ALTERNATE BENEFICIARY IF PRIMARY BENEFICIARY IS PRE-DECEASED OR IS DIVORCED FROM ME

LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP
ADDRESS	CITY	STATE	ZIP CODE

DATE CARD IS SIGNED:

MONTH DAY YEAR

SIGNATURE IN INK - USE FULL NAME

CENTRAL LABORERS' PENSION & WELFARE FUNDS
P.O. BOX 1267, JACKSONVILLE, IL 62651-1267
PHONE: 800-252-6571

LIST BELOW NAMES OF YOUR SPOUSE AND UNMARRIED CHILDREN THAT ARE DEPENDENT UPON YOU FOR AT LEAST 1/2 OF THEIR SUPPORT

LIST FULL NAMES IN ORDER OF AGE - ELDEST FIRST	PLACE AN "X" BY RELATIONSHIP			DATE OF BIRTH		
	SPOUSE	DAUGHTER	SON	MONTH	DAY	YEAR

CENTRAL LABORERS' PENSION & WELFARE FUNDS
PO BOX 1267, JACKSONVILLE, IL 62651-1267
PHONE: 800-252-6571

Great Plains Laborers' Vacation Fund

Beneficiary Designation Form

(Payment Upon Death of Participant; Review Article V, Section B of the SPD)

☐ *Check box if Name or Address Changed below*

Participant Full Name ____________________ *Participant Social Security Number* ____________________

Participant Mailing Address - Street, City, State, Zip ____________________ *Participant Date of Birth* ____________________

All information MUST be completed in order to be processed. *(percentages must total 100%)*

PRIMARY BENEFICIARY*(IES)*

1) *Social Security Number* | *Date of Birth* | *Relationship to Participant* | *Percent (%)*

Beneficiary Full Name | *Mailing Address - Street, City, State, Zip*

2) *Social Security Number* | *Date of Birth* | *Relationship to Participant* | *Percent (%)*

Beneficiary Full Name | *Mailing Address - Street, City, State, Zip*

3) *Social Security Number* | *Date of Birth* | *Relationship to Participant* | *Percent (%)*

Beneficiary Full Name | *Mailing Address - Street, City, State, Zip*

** If additional space is needed please use the reverse side of this form.* **(TOTAL 100%)**

ALTERNATE BENEFICIARY*(IES)* *(in the event no Primary Beneficiary survives)*

1) *Social Security Number* | *Date of Birth* | *Relationship to Participant* | *Percent (%)*

Beneficiary Full Name | *Mailing Address - Street, City, State, Zip*

2) *Social Security Number* | *Date of Birth* | *Relationship to Participant* | *Percent (%)*

Beneficiary Full Name | *Mailing Address - Street, City, State, Zip*

3) *Social Security Number* | *Date of Birth* | *Relationship to Participant* | *Percent (%)*

Beneficiary Full Name | *Mailing Address - Street, City, State, Zip*

** If additional space is needed please use the reverse side of this form.* **(TOTAL 100%)**

Participant Signature ____________________ *Date* ____________________

4208 W. Partridge Way, Unit 3 • Peoria • Illinois 61615-5650 (309) 692-0860 • (866) 692-0860 • Fax: (309) 692-0862

SOLUTIONS FOR THE UNION WORKPLACE

ENROLLMENT AND BENEFICIARY FORM

PLEASE PRINT

Please submit this form to:
GROUP ELIGIBILITY DEPARTMENT
The Union Labor Life Insurance Company
8403 Colesville Road • Silver Spring, MD 20910
Phone: (202) 962-8978 • Fax: (202) 682-6661
Toll-free: (888) 222-8573

INSTRUCTIONS: This form is to be utilized for enrollment and beneficiary purposes only. All correspondence and questions should be addressed to the Fund/Employer maintaining your eligibility information.

For all new additions and reinstatements, complete the entire form, and sign at the bottom.

For all other needs, complete the appropriate section, and sign at the bottom.

Please Check: ☐ **New Enrollment** ☐ **Reinstatement** ☐ **Address Change** ☐ **Beneficiary Change**

SECTION A – Policyholder Information

Name of group policyholder: ______________________ Policy number: ____________

Effective date: ______________________ Local/Bill ID: ____________

SECTION B – Insurance Amount

Life amount: $ ________ AD&D amount: $ ________ AH amount: $ ________ LTD amount: $ ________

Billing classes: ________ ________ ________ ________

☐ Duplicate certificate request

SECTION C – Insured Information

☐ Male ☐ Female ☐ Active ☐ Retiree

Name of insured: ______________________
Last First Middle

Address: ______________________

City: ______________________ State: ________ Zip: ________

SSN: ______________________ Date of birth: ____________

Occupation: ____________ Weekly earnings: ____________ Date started working: ____________

SECTION D – Beneficiary

NOTE: If the beneficiary is being changed, the new beneficiary will replace all prior designations and will be effective as of the date this form is signed.

Beneficiary name	Relationship to Insured	Date of birth	% of share	SSN:
Primary: 1.			%	
2.			%	
Contingent: 1.			%	
2.			%	

INSURED SIGNATURE (Required): X ______________________ Date: ____________

WITNESS SIGNATURE (Required for new adds, reinstatements or beneficiary change): X ______________________ Date: ____________

PLEASE COMPLETE REVERSE SIDE

SOLUTIONS FOR THE UNION WORKPLACE

ENROLLMENT AND BENEFICIARY FORM

PAGE 2

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FRAUD NOTICE:

California: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.

I attest that I have reviewed, understand and acknowledge the fraud warning(s).

Member or Claimant's signature: X_______________________________ Date: ____________

PLEASE COMPLETE REVERSE SIDE

SOLUTIONS FOR THE UNION WORKPLACE

ENROLLMENT AND BENEFICIARY FORM

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- **For all new additions and reinstatements, complete the entire form, and sign at the bottom.**
- **For all other needs, complete the appropriate section, and sign at the bottom.**

Please check: ☐ **New enrollment** ☐ **Reinstatement** ☐ **Address Change** ☐ **Beneficiary Change**

SECTION A – Policyholder Information

Name of group policyholder: Great Plains Laborers' District Council Policy number: G-3254 & C-4518

Effective date: July 1, 2014 Local/Bill ID: ________

SECTION B – Insurance Amount

Life amount: $2,000 AD&D amount: $2,000 AH amount: $________ LTD amount: $________

Billing classes: ________ ________ ________ ________

☐Duplicate certificate request

SECTION C – Insured Information

☐ Male ☐ Female
☐ Active ☐ Retiree

Name of insured: ________
Last First Middle

Address: ________

City: ________ State: ________ Zip: ________

SSN: ________ Date of birth: ________

Occupation: Laborer Weekly earnings: ---------------------- Date started working: ________

SECTION D – Beneficiary

NOTE: If the beneficiary is being changed, the new beneficiary will replace all prior designations and will be effective as of the date this form is signed.

Beneficiary name	Relationship to Insured	Date of birth	% of share	SSN:
Primary: 1.			%	
2.			%	
Contingent: 1.			%	
2.			%	

INSURED SIGNATURE (Required): X________ Date: ________

WITNESS SIGNATURE (Required for new adds, reinstatements or beneficiary change): X________ Date: ________

PLEASE READ AND COMPLETE ALL PAGES

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ENROLLMENT AND BENEFICIARY FORM

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Member or Claimant's signature: X____________________ Date: __________

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