

Date

Dear Participant:

Enclosed, please find the Retirement and Pension Plan for Officers and Employees of the New York City District Council of Carpenters and Related Organizations Beneficiary form. Kindly complete the form in its entirety, sign, date, and return to the Benefit Funds Office.

As an eligible participant of the Retirement and Pension Plan for Officers and Employees of the New York City District Council of Carpenters and Related Organizations, you are entitled to certain benefits. These benefits can be designated to a named beneficiary (ies). Your Beneficiary may be one or more person(s), a trust, an estate, a charity, etc. In addition to naming a Beneficiary, you can also designate a contingent Beneficiary. A contingent Beneficiary receives benefits in the event the primary Beneficiary dies before you. If you do not name a beneficiary, or your beneficiary predeceases you, the death benefit will be paid in the order set forth in the plan (e.g. to your spouse, then children, then parents, then siblings, then your estate). You are automatically the Beneficiary for any life insurance coverage on your dependents.

You may change your Beneficiary at any time by submitting a new Beneficiary designation form to the Fund Office; upon receipt of the new beneficiary form any prior designations will be revoked. Beneficiary designation forms are available from the Fund Office. It is important to keep your Beneficiary designation and contact information up to date.

Please note that forms not completed in their entirety will not be accepted, nor will new forms be accepted after your date of death.

Please return your original, signed, and dated Beneficiary form to:

**Benefit Funds Office  
395 Hudson Street  
New York, NY 10014**

If you have any questions, please contact the Benefit Funds Office at **(212) 366-7300 or (800) 529-3863**.

Sincerely,

Benefit Funds Office

**RETIREMENT AND PENSION PLAN FOR OFFICERS AND EMPLOYEES OF THE  
NEW YORK CITY DISTRICT COUNCIL OF CARPENTERS AND RELATED  
ORGANIZATIONS BENEFICIARY DESIGNATION FORM**

*To designate, revoke, or change a beneficiary, please complete, sign, and date this Beneficiary Designation Form and return the original to the NYC District Council of Carpenters Welfare Fund at 395 Hudson Street New York, NY 10014*

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Street Address: \_\_\_\_\_  
City State Zip Code

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Marital Status: Single ( ) Married ( ) Divorced ( ) Widowed ( )

Email: \_\_\_\_\_ Hire Date: \_\_\_\_\_

**PRIMARY BENEFICIARY INFORMATION: IF DESIGNATING MORE THAN ONE PRIMARY BENEFICIARY  
PLEASE USE THE BACK)**

Full Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_  
City State Zip Code

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ % of Benefit: \_\_\_\_\_

**CONTINGENT BENEFICIARY INFORMATION: (IF DESIGNATING MORE THAN ONE CONTINGENT  
BENEFICIARY PLEASE USE THE BACK)**

Full Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_  
City State Zip Code

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ % of Benefit: \_\_\_\_\_

**I hereby designate the above named beneficiary(ies) to receive any death benefits or unpaid benefit due upon my death from the New York City District of Carpenters Welfare Fund. I further understand that beneficiary designations may be changed by me at any time.**

**Please be aware that this form does not guarantee an assignment of benefits.**

**Full Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

NYC District Council of Carpenters Welfare Fund  
395 Hudson Street  
New York, NY 10014

**PRIMARY BENEFICIARY INFORMATION:**

Full Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City State Zip Code  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ % of Benefit: \_\_\_\_\_

**PRIMARY BENEFICIARY INFORMATION:**

Full Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City State Zip Code  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ % of Benefit: \_\_\_\_\_

**CONTINGENT BENEFICIARY INFORMATION:**

Full Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City State Zip Code  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ % of Benefit: \_\_\_\_\_

**CONTINGENT BENEFICIARY INFORMATION:**

Full Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Relationship to you: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City State Zip Code  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ % of Benefit: \_\_\_\_\_

**\*\*\*Please ensure that the designated percentage of benefits equals to a 100%\*\*\***