OPERATING ENGINEERS LOCAL NO. 3 BENEFICIARY DESIGNATION FORM (PART II) (ALL BENEFITS EXCEPT PENSION AND ANNUITY PLANS)

DESIGNATION OF BENEFICIARY

Fringe Benefits Office, 3920 Lennane Drive, Suite 200, Sacramento, CA 95834 (510) 748-7450

This form applies to the following benefits, as applicable:

- 1. OPERATING ENGINEERS LOCAL UNION 3 BURIAL BENEFIT
- OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND BURIAL BENEFIT
- 3. OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND LIFE INSURANCE
- 4. HAWAII OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND BURIAL BENEFIT
- 5. HAWAII OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND LIFE INSURANCE
- PENSIONED OPERATING ENGINEERS HEALTH & WELFARE TRUST FUND BURIAL BENEFIT
- OPERATING ENGINEERS PUBLIC & MISC HEALTH & WELFARE TRUST FUND BURIAL BENEFIT
- 8. OPERATING ENGINEERS PUBLIC & MISC HEALTH & WELFARE TRUST FUND LIFE INSURANCE

SPOUSE'S NAME (If Legally Married) DATE OF MARRIAGE SPOUSE'S SOCIAL SECURITY NO. IF DIVORCED OR LEGALLY SEPARATED, GIVE DATE (S) EXPLANATION REGARDING DESIGNATION OF BENEFICIARY The term "Beneficiary" means a person (including a trust) designated by a Participant. You may designate the same person to receive all benefits named of this form, or different persons to receive each of them. If you list more than one beneficiary, they shall share the applicable benefits equally unless of You also may designate a contingent beneficiary to receive benefits in the event of the death of your primary beneficiary(ies). If you do not designate applicable benefits will be payable as provided under the Plan. BESURE TO COMPLETE THE ENTIRE FORM AND RETURN IT TO THE FRINGE BENEFITS OFFICE. BENEFICIARY DESIGNATION I, Social Security No	LAST NAME		FIRST NAME IN FULL		MIDDLE NAME IN FULL		
DATE OF BIRTH CURRENT MARITAL STATUS (Please Circle One) /	STREET ADDRESS		CITY	STATE	ZIP		
Married Never Married Divorced Legally Separated Divorced & Remarried Wides PATE OF MARRIAGE	SOCIAL SECURITY NO.	_	TELEPHONE NO.	I			
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I,	BE	SURE TO COMPLETE THE EN	NTIRE FORM AND RETURN I	T TO THE FRINGE BENEFIT	S OFFICE.		
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PRINT NAME OF BENEFICIARY SOCIAL SECURITY NO. RELATIONSHIP OF SOCIAL SECURITY NO. RELATIONSHIP OF SOCIAL SECURITY NO. RELATIONSHIP OF SOCIAL SECURITY NO.	Please note the following:				ocument.		
ADDRESS PHONE CONTINGENT BENEFICIARY SOCIAL SECURITY NO. RELATIONSHIP	In the event of my	death, pay any applicable bene	efits to:				
CONTINGENT BENEFICIARY SOCIAL SECURITY NO. RELATIONSHIP	PRINT NAME OF BENEFICE	ARY	SOCIAL SECURITY NO.	RELATIO	ONSHIP %	of Distribution	
	ADDRESS	_	PHONE				
ADDRESS PHONE	CONTINGENT BENEFICIAR	Y	SOCIAL SECURITY NO.	RELATIO	ONSHIP %	of Distribution	
	ADDRESS		PHONE				