Southern California Drug Benefit Fund

BENEFICIARY DESIGNATION FORM

Return to: P.O. Box 27920 Los Angeles, CA 90027-0920 Ph: (323) 666-8910

Participant Information

☐ Active or ☐ Retired

First Name _____ MI _____ Last Name _____
Social Security No. __ __ __ -- -- __ __ -- -- __ __ __ __ Date of Birth __ __ / __ __ / __ __ __ __
Street Address _____
City / State /Zip _____ Phone (__ __ __) __ __ __ -- __ __ __ __
Email Address _____ Cell (__ __ __) __ __ __-- __ __ __ __

PLEASE READ THE INSTRUCTIONS ON THE BACK OF THIS DOCUMENT BEFORE COMPLETING.

Primary Beneficiary #1

First Name _____ MI _____ Last Name _____
SSN: __ __ __ -- -- __ __ -- -- __ __ __ __ ☐ Male or ☐ Female Date of Birth __ __ / __ __ / __ __ __ __
Address/City/State/Zip _____
Relationship to Participant _____ Phone (__ __ __) __ __ __ -- __ __ __ __
Email Address _____ Cell (__ __ __) __ __ __ -- __ __ __ __

Primary Beneficiary #2

First Name _____ MI _____ Last Name _____
SSN: __ __ __ -- -- __ __ -- -- __ __ __ __ ☐ Male or ☐ Female Date of Birth __ __ / __ __ / __ __ __ __
Address/City/State/Zip _____
Relationship to Participant _____ Phone (__ __ __) __ __ __ -- __ __ __ __
Email Address _____ Cell (__ __ __) __ __ __ -- __ __ __ __

Primary Beneficiary #3

First Name _____ MI _____ Last Name _____
SSN: __ __ __ -- -- __ __ -- -- __ __ __ __ ☐ Male or ☐ Female Date of Birth __ __ / __ __ / __ __ __ __
Address/City/State/Zip _____
Relationship to Participant _____ Phone (__ __ __) __ __ __ -- __ __ __ __
Email Address _____ Cell (__ __ __) __ __ __ -- __ __ __ __

THIS SECTION IS OPTIONAL. PLEASE READ THE BACK SIDE OF THIS FORM FOR INFORMATION ON ALTERNATE BENEFICIARIES.

Alternate Beneficiary #1

First Name _____ MI _____ Last Name _____
SSN: __ __ __ -- -- __ __ -- -- __ __ __ __ ☐ Male or ☐ Female Date of Birth __ __ / __ __ / __ __ __ __
Address/City/State/Zip _____
Relationship to Participant _____ Phone (__ __ __) __ __ __ -- __ __ __ __
Email Address _____ Cell (__ __ __) __ __ __ -- __ __ __ __

Alternate Beneficiary #2

First Name _____ MI _____ Last Name _____
SSN: __ __ __ -- -- __ __ -- -- __ __ __ __ ☐ Male or ☐ Female Date of Birth __ __ / __ __ / __ __ __ __
Address/City/State/Zip _____
Relationship to Participant _____ Phone (__ __ __) __ __ __ -- __ __ __ __
Email Address _____ Cell (__ __ __) __ __ __ -- __ __ __ __

In accordance with and subject to the terms and regulations of the Southern California Drug Benefit Fund, in the event of my death I hereby designate my beneficiary(ies), as indicated above, to receive the death benefit. **The right to change the beneficiary designated without the consent of the beneficiary is hereby reserved to the undersigned:**

Participant's Signature _____ **Date** __ __ / __ __ / 2 0 __ __

Complete form in black ink. Do not use white out or cross out information. Contact us if you need a new form.

Rev. 6/2014

Southern California Drug Benefit Fund

BENEFICIARY DESIGNATION FORM

Instructions

Use this form to designate one or more beneficiaries who will receive benefits in the event of your death. A beneficiary must be a person, your Estate or Trust for the benefit of one of more persons. If your beneficiary is a minor (under age 18), no benefits will be paid until the Drug Benefit Trust Fund receives sufficient written proof of the minor's guardian, conservator, or custodian.

If you do not designate a Beneficiary of if the designated Beneficiary(ies) dies before you, the Plan provides that the death benefit will be payable in the following order:

1. Your spouse. **If none, then**

2. Your natural children, including legally adopted children payable in equal shares. **If none, then**

3. To your parents, including adoptive parents, payable in equal shares. **If none, then**

4. **No Death Benefit is payable**, however the Fund will pay a reasonable amount, not to exceed the amount of the death benefit, to the person who presents proper evidence that he/she has actually incurred expenses for your burial. Such proper evidence includes receipts for goods and services received, and proof of payment by the person making the claim.

PLEASE REVIEW AND UPDATE THE DESIGNATIONS ON THIS FORM FROM TIME TO TIME, ESPECIALLY FOLLOWING A BIRTH, DEATH, MARRIAGE, DIVORCE OR REMARRIAGE.

Primary Beneficiary

This is the person you designate to receive the benefit after your death. If you name one Primary Beneficiary, he or she must survive you in order to receive the benefit. If you name two or more Primary Beneficiaries, those who survive you will share the Benefit equally; those who do not survive you will receive nothing.

Alternate Beneficiary

This is the person you designate to receive the benefit in the event that no Primary Beneficiary survives you. If you name one Alternate Beneficiary, he or she must survive you in order to receive the benefit. If you name two or more Alternate Beneficiaries, those who survive you will share the benefit equally; those who do not survive you will receive nothing.

Please note that the death benefit will distributed to the Alternate Beneficiary(ies) only if there are no surviving Primary Beneficiaries at the time of your death. Thus, if at least one Primary Beneficiary survives you, that Primary Beneficiary will receive the entire death benefit, and the Alternate Beneficiary(ies) will receive nothing.

12-Month Time Limit for Filing a Death Benefit Claim

All death benefit claims must be filed within 12 months of the date of death. It is your responsibility to advise your Beneficiary(ies) of the 12-month time limit.

Participant's Signature

Participant must sign and date the Beneficiary Designation Form to be valid. Complete this form in **black** ink. Do not use white out or cross out information. Contact us if you need a new form mailed to you.