Twin City Hospital Workers Pension Plan

3001 Metro Drive, Suite 500
Bloomington, MN 55425
Telephone: (952) 814-4605 – Toll Free: (800) 535-6373

Beneficiary Designation Form for Pre-Retirement Lump Sum Death Benefits

The receipt of this form does not signify that you are qualified for a Pre-Retirement Lump Sum Death Benefit. However, you may become qualified for this benefit in the future. Therefore, you must complete this form and return it to the Fund office at the address listed above. Please return all pages of this form.

Effective January 1, 2009, if you are Vested and decease prior to commencing your retirement benefit, your Spouse or Beneficiary may qualify for a Lump Sum Death Benefit equal to $500.00 multiplied by your years of Vesting Service.

In order to qualify for this benefit, you must be actively employed by a Participating Employer in Covered Service at the time of your death.

Instructions for Completing Form:

If you are Single or Married and electing your spouse as your beneficiary complete and sign part 2.

If you are married and your spouse is waiving their right to the benefit complete and sign part 3.

Participants Complete Part 1.

1. Plan Participants Personal Information

Name of Primary Beneficiary	
Street Address:	
City, State & Zip Code:	
Social Security Number:	
Telephone Number:	
Date of Birth:	

2. Primary Beneficiary Information

Name of Primary Beneficiary	
Street Address:	
City, State & Zip Code:	
Social Security Number:	
Telephone Number:	
Date of Birth:	
Relationship to Participant:	

If my primary beneficiary is not living at the time of my death

Contingent Beneficiary Information

Name of Primary Beneficiary	
Street Address:	
City, State & Zip Code:	
Social Security Number:	
Telephone Number:	
Date of Birth:	
Relationship to Participant:	

Signature of Participant Date Signed

BENEFICIARY DESIGNATION – SPOUSAL CONSENT

COMPLETE THIS PORTION ONLY IF YOUR SPOUSE IS NOT THE SOLE PRIMARY BENEFICIARY

I hereby consent to my spouse's designation of the primary Beneficiary or Beneficiaries listed above. I understand that my spouse cannot change any primary Beneficiary in the future without my written consent. I understand that I do not have to sign this consent. I am signing this consent voluntarily. I further understand that if I do not sign this consent, I will be entitled to receive any benefit payable under the Plan as a result of my spouse's death.

Signature of Participant's Spouse: ________________________________ Date: ____________

WITNESSED BY NOTARY PUBLIC

State of (_________________)

County of (_______________)

On the _______day of __________________, 20______, before me came _________________________________to me known and known to me to be the person described in and who executed the foregoing statement and (s)he duly acknowledged to me that (s)he executed the same.

(seal) ____

(Signature of Notary Public)