LIFE INSURANCE BENEFICIARY FORM
(Please Type or Print Clearly)

Last Name     First   Middle                        Social Security Number

Home Address                                          Date of Birth

City State and Zip                                    Local Union

Employer                                              Date Employed

Beneficiary for the policy shall be:

<table>
<thead>
<tr>
<th></th>
<th>Primary Beneficiary</th>
<th>Percentage</th>
<th>Relationship to Insured</th>
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</thead>
<tbody>
<tr>
<td>a)</td>
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<table>
<thead>
<tr>
<th></th>
<th>Contingent Beneficiary (paid only if primary beneficiaries are deceased)</th>
<th>Percentage</th>
<th>Relationship to Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>b)</td>
<td></td>
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</table>

Please include Beneficiary's address if different from member's.

Signature – (This beneficiary designation cancels any prior beneficiary designation and shall be effective on the date received by the Administrative Office) Date

DESIGNATING A BENEFICIARY

If one individual is designated, use their full name, for example "Mary J. Smith", not "Mrs. John Smith".

If two individuals are to be named, designate as follows: "Mary Smith, wife and Dorothy Smith, daughter." Be sure to state the relationship, for example, "wife", "son", "daughter".

If more than one beneficiary is designated, benefits will be divided equally, unless you designated otherwise.

You must complete a new card to change your beneficiary designation. A card must be on file at the Administrative Office in order to be valid.

Contact the Administrative Office if you have any questions. (562) 463-5065 – (800) 386-4350

When form is completed mail to:

Office and Professional Employees Locals 30 & 537
Retirement and Health & Welfare Trust Funds
1200 Wilshire Blvd., 5th Floor
Los Angeles, CA  90017-1906

03/2022